MSS Prenatal Screening Guide

Date:	Time visit started:	_□AM □PM	Time visi	sit ended AM DPM Home visit/ Office visit/Alternate site
Client name: Race/Ethnicity/Tribal affiliation:				Date of birth: / / Age at conception:
				EDD/ Delivery Date:/ /
Education Level	:			Currently in school? Y or N
Living/housing s	ituation:			Currently working? Y or N
Primary language	e spoken:			Language barriers: Y or N
Prenatal medical	provider:		_	Medical provider's telephone #

	QUESTIONS	RISK/PURPOSE
		BOLD = Targeted Risk Factors
I am going to ask some questions to better help us support you during this pregnancy. This information will be kept confidential. Please let me know if you have any concerns or questions as we go along.		Rapport building
1.	 How is your pregnancy going? How are you feeling? How are you feeling about being pregnant? Is this good timing for your pregnancy? Y or N Tell me more. Have you had any changes in your appetite or sleep habits? Y or N (If yes) What? 	 Rapport building Check for any warning signs Adjustment to pregnancy If client is showing any signs of depression she will need further screening
2.	Have you seen a medical provider for this pregnancy? Y or N (If yes) When did you first see your medical provider? When is your next appointment? (If no) Why don't you have a medical provider? (If no medical provider skip to Q #4)	 Referral/link to medical care Prenatal medical care: Greater than or equal to (≥) 14 and less than (<) 24 weeks and no prenatal care started at time of screening Greater than or equal to (≥) 24 weeks gestation and no prenatal care started at time of screening Started prenatal care during third trimester (greater than or equal to (≥) 24 weeks gestation)
3.	(If seen by a medical provider) Has your medical provider told you about any health or medical concerns with your current pregnancy, such as high blood pressure, gestational diabetes, preterm labor, or pregnant with two or more babies?	 Gestational Diabetes Hypertension during pregnancy (PIH/Gestational Hypertension) Preterm labor Prescribed bed rest due to conditions that could lead to preterm birth, i.e. placenta previa or placenta abruption Multiple Gestation
4.	 How much did you weigh before this pregnancy?lb Have you had your weight checked recently?lb Date : Height:(feet and inches) Please document how you obtained the client's weight (agency scale, client reported, another source-medical provider, or WIC). MSS providers will need to determine the client pre-pregnancy BMI and pregnancy weight gain. 	Pre-pregnancy BMI: □ Less than (<) 18.5 BMI □ 25 to 29.9 BMI □ Greater than or equal to (≥) 30 BMI

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5.	Is this your first pregnancy? Y or N (If yes) skip to Q #8 (If no) • How many times have you been pregnant? • Have any of them been miscarriages, stillbirth or early infant death? Y or N (If yes) How many and when? • When did your last pregnancy end? • Did you have fertility treatment with this pregnancy? Y or N	 35 years of age or older and this is the first pregnancy Inter-pregnancy interval less than 9 months from end of last pregnancy (including miscarriages or terminations) Fetal death history (greater than (>) 20 weeks gestation) 35 years of age or older at the time of conception and used ART
6.	 (If any live births) Did your baby (babies) have any health or medical problems at birth? If yes, what were they?	 Prior LBW (less than (<) 5# 8 oz) and/or Premature Infant (less than (<) 37 weeks) Prior preterm birth due to spontaneous preterm labor* Prior rupture of the membranes* *If marked and singleton gestation, refer to provider for 17P treatment.
7.	Did you have gestational diabetes, high blood pressure, depression, or postpartum depression with your last pregnancy? (If yes) Tell me more.	 History Gestational Diabetes with last pregnancy History of Gestational Hypertension History Perinatal Mood Disorder or postpartum depression with last pregnancy
8.	Do you have any health problems or medical conditions not related to pregnancy? (If yes) Tell me more. Examples- Hypertension, diabetes, treatment of mental health issues, etc.?	 Chronic Hypertension Diabetes- type 1 or 2 Perinatal Mood Disorders/ Depression Severe Mental Illness
9	Are you currently taking any prescribed medications, over the counter medications, supplements, vitamins, and/or home remedies? Y or N (If yes) What are they and how much/often do you take them? (If yes and has prenatal care provider) Have you discussed taking these during pregnancy with your prenatal care provider? Y or N (If no) Why not?	 Medications related to psychiatric issues, diabetes, and hypertension. Non-prescriptive use of prescription drugs Supplements, prescription drugs Prenatal vitamins/folic acid/iron
10	 When was the last time you saw a dentist? Do you have any problems with your teeth or gums that affect how you eat? Y or N (If yes) What? 	Referral to dental care
11	Do you ever run out of food before the end of the month or cut down on the amount you eat to feed others? Y or N (If yes) Tell me more. Depending on feedback follow up with: • Are you currently on WIC? Y or N • Basic Food Program (food stamps)? Y or N • Are you aware of other food programs in the area? Y or N	 Food Insecurity Referral to WIC/Basic Food Program (food stamps) and/or food banks

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The	following questions we ask everyone, because they have to do with health and safety.	Transition
12	 Have you ever smoked or used tobacco or nicotine products? Y or N (If no) skip to Q #13 (If yes) Did you use during the three months before you became pregnant? Y or N Are you currently using tobacco/nicotine? Y or N (If no) skip to Q #13 (If yes) Are you trying to quit? Y or N Tell me more. 	 Current Maternal Tobacco/Nicotine Use Quit tobacco/nicotine 3months prior to pregnancy or at time of pregnancy diagnosis
	Are you interested in getting help to quit? Y or N	
13	Does anyone smoke inside your home and/or car? Y or N	Basic health message- Second hand smoke
14	 When was the last time you drank alcohol? Are you currently drinking alcohol? Y or N (If no) skip to Q #15 Are you trying to stop? Y or N Tell me more Are you interested in getting help to stop? Y or N 	 Alcohol use/Abuse- See definitions
15	 When was the last time you used illicit drugs? (If never) skip to Q #16	Substance Use/Abuse- See definitions
16	In the last year, has your partner or FOB physically threatened or tried to hurt you? Y or N (If yes) Tell me more.	 Intimate partner violence within last year
17	In the last month, have you felt down, depressed, or hopeless? Y or N (If yes) Client needs standardized depression screening tool completed.	Mental Health
18	Have you ever received mental health services or counseling? Y or N (If yes) Client needs clinical assessment.	Mental Health
19	Who can you count on for help/support during this pregnancy? Who can you talk to about stressful things in your life?	Social Support
20	Is there any information or resources you would like us to help you with during this pregnancy? Y or N (If yes) Client wants help with	Basic referrals- housing, transportation, CBE Health messages Client's needs
Screener, document whether the client discloses or shows signs that she is severely developmentally disabled in a way that may impact her ability to take care of herself during the pregnancy or take care of a child.		Developmental Disability- women with severe developmental disability which impacts the woman's ability to take care of herself during the pregnancy or her infant postpartum

Was there anyone at the appointment who prevented you from asking any questions or may have influenced the client's

responses? Y or N (If yes) Describe:

Client Name: ______ Staff Signature: ______ Client I.D. number_____

Date: _____