Los Angeles County Department of Public Health
Comprehensive Perinatal Services Program
600 S. Commonwealth Ave., Suite 800
Los Angeles, CA 90005
(213)639-6419 Fax (213) 639-1034

Joanne Roberts, PHN
Perinatal Services Coordinator
(213) 639-6427
jroberts@ph.lacounty.gov

Otilia Elszy, PHN
Assistant Coordinator
South LA, Southeast LA Co.
(213) 639-6428
otelszy@ph.lacounty.gov

I Jean Floyd, PHN
Assistant Coordinator
North LA Co., San Gabriel Valley
(213) 639-6429
jfloyd@ph.lacounty.gov

Carol Phillips, PHN
Assistant Coordinator
Southwest LA.Co., So.Bay, Downtown LA
(213) 639-6437
cphillips@ph.lacounty.gov

Jenny Morales, PHN
Assistant Coordinator
Hollywood, SF Valley, Antelope Valley, West
(213) 639-6437
jmorales@ph.lacountygov

Thelma B. Hayes, MA, RD,CLE
Nutrition Consultant
(213) 639-6423
thayes@ph.lacounty.gov

Paula Binner, LCSW
Clinical Social Work Consultant
(213)639-6424
pbinner@ph.lacounty.gov

Katie Balderas, MPH
Senior Health Educator
(213) 639-6425
kbalderas@ph.lacounty.gov

Christian Murillo, MPH
Health Education Assistant
(213) 639-6422 Office
cmurillo@ph.lacounty.gov

For CPSP training attendance certificates please contact:
Bertha Solis
Staff Assistant
(213) 639-6445
bsolis@ph.lacounty.gov

City of Long Beach
Dept. of Health & Human Services
Alyssa Hartlaub, PHN
Perinatal Services Coordinator
2525 Grand Ave. Room 250
(562) 570-7986/ (562) 570-4099 fax
alyssa.hartlaub@longbeach.gov

Pasadena City Health Dept.
Geraldine Perry-Williams., PHN
Perinatal Services Coordinator
1845 Fair Oaks Ave. 2nd Floor
(626) 744-6092/ (626) 744-6112 fax
gperry-williams@cityofpasadena.net

Los Angeles County CPSP
Web Site Address:
www.publichealth.lacounty.gov/mch

Provider: _____

Patient: _____ DOB: _____ EDD: _____

Date Discussed	SUBJECT	Handout Given&Reviewed	
		Yes	No
_____	☐ Perinatal services to be provided (including CPSP) Name of Handout: *See Handout STT/HE-7	☐	☐
_____	☐ Who will provide services Name of Handout or N/A_____	☐	☐
_____	☐ Where services will be provided Name of Handout or N/A_____	☐	☐
_____	☐ Danger signs of pregnancy-what to do if they occur Name of Handout: *See Handout STT/HE-9	☐	☐
_____	☐ Patient Rights and Responsibilities Name of Handout:* See Handout STT/HE-11	☐	☐
_____	☐ HIV information/counseling given & HIV testing offered Name of Handout:* See Handout STT/HE-35	☐	☐
_____	☐ Substances to avoid during pregnancy Name of Handout or N/A_____	☐	☐
_____	☐ Group Classes available Name of Handout or N/A_____	☐	☐
_____	☐ Fetal movement monitoring (24-28 wks.) Name of Handout:_____	☐	☐
_____	☐ Integrated Prenatal Screening (a)1st Trimester lab:10 wks/ 0days 13 wks/6days (b) 2nd Trimester lab: 15-wks/ 0 days- 20-wks/0 days. Name of Handout:_____	☐	☐
_____	☐ Genetic Risks/Testing Name of Handout or N/A_____	☐	☐
_____	☐ Delivery Site Options Name of Handout or N/A_____	☐	☐
_____	☐ Financial Responsibility Name of Handout or N/A_____	☐	☐
_____	☐ Other Subject/s_____	☐	☐
		☐	☐

The information checked above has been reviewed with me and I have had the opportunity to ask questions. I understand that as an active participant in my perinatal care, it is my responsibility to ask questions when I have a concern or problem.

Date				Client Signature		Practitioner /CPHW Signature		Total Minutes
		Initial Client Orientation						
		Follow-Up Orientation						
		Follow-Up Orientation						
		Follow-Up Orientation						

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Prenatal Combined Assessment / Reassessment Tool

Initial _____/_____ (1st OB) Date Weeks 2nd Trimester _____/_____ (14-27 weeks) Date Weeks 3rd Trimester _____/_____ (28 weeks-Delivery) Date Weeks

This Prenatal Combined Assessment /Reassessment Tool has received California State Department of Health Services approval and **MAY NOT BE ALTERED** except to be printed on your logo stationery.

Patient Name:_____ Date Of Birth:_____

Health Plan:_____ Identification No.: _____

Provider:_____ Hospital: _____ Location: _____

Case Coordinator/Manager:_____ EDC: _____

Dx. OB High Risk Condition:_____

Personal Information

1. Patient age: o Less than 12 years ↙ o 12-17 years ↙ o 18-34 years o 35 years or older
2. Are you: o Married o Single o Divorced/Separated o Widowed o Other: _____
3. How long have you lived in this area? _____ yrs./mos. Place of birth: _____
4. Do you plan to stay in this area for the rest of your pregnancy? o Yes o No
5. Years of education completed: o 0-8 years o 9-11 years o 12-16 years o 16+ years
6. What language do you prefer to speak: o English o Spanish o Other: _____
7. What language do you prefer to read: o English o Spanish o Other: _____
8. Which of the following best describes how you read:
   o Like to read and read often o Can read, but read slowly or not very often o Do not read
9. Father of baby: (name) _____ His preferred language: _____ Education: _____ Age: _____
10. Was this a planned pregnancy? o Yes oNo
11. How do you feel about being pregnant now?
    0-13 wks: o Good o Troubled, please explain: _____
    14-27 wks: o Good o Troubled, please explain: _____
    28-40 wks: o Good o Troubled, please explain: _____
12. Are you considering (circle)adoption/abortion? o No o If Yes, Do you need information/referrals? oNo o Yes
13. How does the father of the baby feel about this pregnancy? _____
    Your family? _____
    Your friends? _____

Economic Resources

14. a) Are you currently working or going to school? O Yes - type & hr/week: _____ Cal Learn? O Yes ONo

b) Do you plan to work or go to school while you are pregnant? O Yes - type: _____ How long?____ ONo

c) Do you plan to return to work or go to school after the baby is born? O Yes type: _____ ONo

15. Will the father of the baby provide financial support to you and/or the baby? O Yes O No

Other sources of financial help? _____

16. Are you receiving any of the following? (check all that apply)

	0-13 wks:		14-27 wks:		28-40 wks:		Referral Date
	Yes	No	Yes	No	Yes	No	
a. WIC	O	O	O	O	O	O	
b. Food Stamps	O	O	O	O	O	O	
c. AFDC/TANF	O	O	O	O	O	O	
d. Emergency Food Assistance	O	O	O	O	O	O	
e. Pregnancy-related disability insurance benefits	O	O	O	O	O	O	
f. Other:_____	O	O	O	O	O	O	

17. Do you have enough of the following for yourself and your family?

	0-13 wks:		14-27 wks:		28-40 wks:	
	Yes	No	Yes	No	Yes	No
Clothes	O	O	O	O	O	O
Food	O	O	O	O	O	O

Housing

18. What type of housing do you currently live in? O House O Apartment O Trailer Park O Public Housing

O Hotel/Motel O Farm Worker Camp O Emergency Shelter O Car O Other: _____

Any Changes? O No O Yes 14-27 wks: _____ O No O Yes 28-40 wks: _____

19. Do you have the following where you live? ↙ O Yes 0-13 wks O Yes 14-27 wks O Yes 28-40 wks

0-13 wks:	**No:**	O toilet	O stove/place to cook↙	O tub/shower	O electricity	O refrig. ↙	O hot/cold water	O phone
14-27 wks:	**No:**	O toilet	O stove/place to cook↙	O tub/shower	O electricity	O refrig. ↙	O hot/cold water	O phone
28-40 wks:	**No:**	O toilet	O stove/place to cook↙	O tub/shower	O electricity	O refrig. ↙	O hot/cold water	O phone

20. Do you feel your current housing is adequate for you? O Yes O No, please explain: _____

_____

21. Do you feel your home is safe for you and your children? O Yes 0-13 wks O Yes 14-27 wks O Yes 28-40 wks

O No 0-13 wks, please explain: _____

O No 14-27 wks, please explain: _____

O No 28-40 wks, please explain: _____

22. If there are guns in your home, how are they stored? _____ o N/A

23. Do any of your children or your partner's children live with someone else? O N/A O No

O If Yes, please _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Transportation

24. Will you have problems keeping your appointments/attending classes? o No 0-13 wks: o No 14-27 wks: o No 28-40 wks:

o Yes	0-13 wks:	o Transportation	o Child care	o Work	o School	o Other:	_____
o Yes	14-27 wks:	o Transportation	o Child care	o Work	o School	o Other:	_____
o Yes	28-40 wks:	o Transportation	o Child care	o Work	o School	o Other:	_____

25. When you ride in a car, do you use seatbelts? o Never o Sometimes o Always

26. Do you have a car seat for the new baby?
0-13 weeks: o Yes o No 14-27 weeks: o Yes o No 28-40 weeks: o Yes o No

27. How will you get to the hospital? 14-27 weeks: _____ 28-40 weeks: _____

Current Health Practices

28. Do you know how to find a doctor for you and your family? o Yes o No, explain: _____

29. Do you have a doctor for your baby? 14-27 wks: o Yes o No 28-40 wks: o Yes o No Who? _____

30. Have you been to a dentist in the last year? o Yes o No Any dental problems? o No o Yes, please describe:

31. On average, how many total hours at night do you sleep? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____
On average, how many total hours do you nap in the day? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____

32. Do you exercise? o No o Yes, what kind? _____ How often? Minutes/day _____ days/week _____

33. Are you smoking/using chewing tobacco now? ↙ o No 0-13 wks o No 14-27 wks o No 28-40 wks

0-13 wks:	o If Yes,	for how many years? _____	How much per day? _____	Have you tried to quit?	o Yes	o No
14-27 wks:	o If Yes,	how much per day? _____	Have you tried to quit during this pregnancy?		o Yes	o No
28-40 wks:	o If Yes,	how much per day? _____	Have you tried to quit during this pregnancy?		o Yes	o No

34. Are you exposed to second-hand smoke? ↙ at home? o No o Yes at work? o No o Yes

35. Do you handle or have exposure to chemicals? (examples: glue, bleach, ammonia, pesticides, fertilizers, cleaning solvents, etc.)

0-13 wks: (circle)	At work – home – hobbies?	o No	o Yes,	_____
14-27 wks: (circle)	At work – home – hobbies?	o No	o Yes,	_____
28-40 wks: (circle)	At work – home – hobbies?	o No	o Yes,	_____

36. In your home, how do you store the following? o Vitamins: _____
o Medications: _____ o Cleaning agents: _____

Pt. Name _____
Date of Birth _____
Health Plan: _____
Identification No.: _____

37. Are you taking any prescription, over-the-counter, herbal or street drugs? ↙

o None 0-13 weeks o None 14-27 weeks o None 29-40 weeks

Examples: Tylenol®, Tums®, Sudafed®, laxatives, appetite suppressants, aspirin, prenatal vitamins, iron, allergy medications, Aldomet®, Prozac®, ginseng, manzanilla, greta, magnesium, yerba buena, marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other?

o Yes, 0-13 weeks: _____

_____

o Yes, 14-27 weeks: _____

_____

o Yes, 28-40 weeks: _____

_____

38. How much of the following do you drink per day? ↙ ____ Water ____ Milk ____ Juice ____ Decaf Coffee

____ Coffee ____ Punch, Kool-Aid, Tang ____ Soda ____ Diet Soda ____ Herb tea

____ Beer ____ Wine ____ Wine Coolers ____ Hard Liquor ____ Mixed Drinks

14-27 wks: Has this changed? o No o Yes, how? _____

28-40 wks: Has this changed? o No o Yes, how? _____

39. If you use drugs and/or alcohol, are you interested in quitting? o Yes o No

Have you tried to quit? o Yes o No comments: _____

Pregnancy Care

40. Besides having a healthy baby, what are your goals for this pregnancy? _____

_____

41. Do you plan to have someone with you:	14-27 weeks:			28-40 weeks:		
During labor?	o Yes	o No	o Unsure	o Yes	o No	o Unsure
When you first come home with the baby?	o Yes	o No	o Unsure	o Yes	o No	o Unsure

42. If you had a baby before, where was that baby(ies) delivered? o N/A o Hospital o Clinic o Home

o Other: _____ Were there any problems? o No o Yes, please explain: _____

43. Have you lost any children? o No o If Yes, please explain: _____

44. Do you have any traditions, customs or religious beliefs about pregnancy? oNo o If Yes, please explain: _____

_____

45 Does the doctor say there are any problems with this pregnancy?

14-27 wks: o No o Yes please describe: _____

28-40 wks: o No o Yes please describe: _____

46. Are you scheduled for any tests?

14-27 wks: o No o If Yes, what: _____

28-40 wks: o No o If Yes, what: _____

Do you have any questions? o No o If Yes, what: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

47. Have you experienced any of the following discomforts during this pregnancy?

If Yes, check box:	0-13 wks:	14-27 wks:	28-40 wks:
Edema (swelling of hands or feet) ↙	O	O	O
Diarrhea ↙	O	O	O
Constipation ↙	O	O	O
Nausea/vomiting ↙	O	O	O
Leg cramps ↙	O	O	O
Hemorrhoids	O	O	O
Heartburn	O	O	O
Vaginal Bleeding	O	O	O
Varicose veins	O	O	O
Headaches	O	O	O
Backaches	O	O	O
Abdominal cramping/contractions	O	O	O

Other: _____ Other: _____ Other: _____

48. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive this time?
O N/A O No O If Yes, please explain: _____

49. Who has given you the most advice about your pregnancy? _____

50. What are the most important things they have told you? _____

51. Are you planning to use birth control after this pregnancy?

14-27 wks: ONo O Undecided If Yes, O what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

28-40 wks: O No O Undecided If Yes, O what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

52. Your current or past behaviors, or the current or past behaviors of your sexual partner(s) may place you at risk for being / becoming infected with HIV, the virus which causes AIDS. Since 1979 have you or any of your sexual partner(s):

(check all that apply)	self	partner(s)	unknown	no
Had sex with more than one partner?				
Had sex with someone you/they didn't know well?				
Been treated for trichomonas, chlamydia, genital warts, syphilis, gonorrhea, or other sexually transmitted infections?				
Had sex with someone who used drugs?				
Had hepatitis B?				
Shared needles?				
Had a blood transfusion since1979?				

Is there any other reason you think you might be at risk for HIV/AIDS? O No O If Yes, please explain: _____

_____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Change in HIV risk status? 14-27 weeks: O No O Yes, what? _____

28-40 weeks: O No O Yes, what? _____

53. Have you been offered counseling/information on the benefits of HIV testing and been offered a blood test for HIV?

0-13 wks: O No (Refer to OB provider)

14-27 wks: O No (Not applicable if previous Yes answer)

28-40 wks: O No (Not applicable if previous Yes answer)

O If Yes, do you have any questions? _____

Educational Interests

54. If you have had experience or received education/information in any of the following topics check Column A. If would you like more information check Column B.

TOPIC	0-13 WKS		14-27 WKS		28-40 WKS		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
How your baby grows (fetal development)									
How your body changes during pregnancy									
Healthy habits for a healthy pregnancy/baby									
Assistance with cutting down/quitting smoking									
Assistance with cutting down/quitting alcohol or drugs									
What happens during labor and delivery									
Hospital Tour									
Helping your child(ren) get ready for a new baby									
How to take care of yourself after the baby comes									
Breastfeeding									
How to take care of your baby/infant safety									
Infant development									
How to avoid sexually transmitted infections/HIV									
Circumcision									

* Teaching Codes: A = Answered questions E = Explained verbally V = Video shown
W = Written material provided S = Visual aids shown I = Interpreter used

55. Is there anything special you would like to learn? O No O Yes, what? _____

56. How do you like to learn new things? O Read O Talk one-on-one O Group education/classes
O Watch a Video O Pictures and diagrams O Being shown how to do it
O Other: _____

57. Will someone be able to attend classes with you? O No O Yes, who? _____

58. Do you have any physical, mental, or emotional conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing or vision problems that may affect the way you learn? O No O Yes: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

Nutrition - A copy of this page should be sent with the client to WIC **Date:** _____

Anthropometric: EDC: _____ WKS GA: ____ Height: _____ Current weight: ____

59. Weight gain in previous pregnancies: 1st: _____ O Unknown 2nd: _____ O Unknown O N/A

Recommended weight gain during pregnancy (check one)

60. Prepregnant weight: _____ lbs. O for underweight women 28-40 lbs. Ofor normal weight women 25-35 lbs.

61. Net weight gain: _____ lbs. O for overweight women 15-25 lbs O for very overweight women 15-20 lbs

O Adequate O Inadequate O Excessive O Weight loss O Weight grid plotted

Biochemical Data:

62. Urine-Date: _____ (circle + or -) Glucose: + - Ketones: + - Protein: + -

63. Blood-Date drawn: _____ Hgb: _____ (<10.5) Hct: _____ (< 32) MCV: _____ Glucose: _____

Clinical Data:

64. O None relevant 65. O Age 17 or less (#1) 66. O Pregnancy interval < 1 yr.

67. O High Parity (≥4 births) 68. O Multiple Gestation 69. O Currently Breastfeeding

70. O Dental Problems (#30) 71. O Serious Infections 72. O Anemia

73. O Diabetes (circle) Prepreg Past preg Current preg comments: _____

74. O Hypertension (circle) Prepreg Past preg Current preg comments: _____

75. O Hx. of poor pregnancy outcome (e.g., preterm delivery, fetal/neonatal loss): _____

76. O Other medical/obstetrical problems (low birth weight, large for gest. age, PIH): Past: _____

Present: _____

77. Psychosocial or Health Education Problems: O Eating disorder O Psychiatric illness (#99) O Abuse (# 102-106)

O Homelessness (#18) O Dev. disability (#58) O Low education (#5) O Other: _____

Dietary:

78. Any discomforts? (#47) O No O If Yes, please check: O Nausea O Vomiting O Swelling O Diarrhea

O Constipation O Leg cramps O Other: _____

79. Do you ever crave/eat any of the following? O No, O If Yes, please check O Dirt O Paint chips O Clay

O Ice O Paste O Freezer Frost O Cornstarch O Laundry starch O Plaster O Other: _____

80. a) Number of meals/day : _____ b) meals often skipped? O No O Yes c) Number of snacks/day : _____

81. Who does the following in your home: a) buys food: _____ b) prepares food : _____

82. Do you have the following in your home: (#19) a) stove/place to cook? O No O Yes b) refrigerator? O No O

83. Are you on any special diet? O No O If yes, please explain: _____

84. a) Any food allergies? O No O If yes, please explain: _____

b) Any foods/beverages you avoid? O No O If yes, please explain: _____

85. Are you a vegetarian? O No O If Yes, do you eat: O Milk Products O Eggs O Nuts O Dried Beans O Chicken/Fish

86. Substance use? O No O Alcohol (#38) O Drugs (#37) O Tobacco (#33) OSecondhand smoke (# 34)

O Present: _____ O Past: _____

87. Currently use? (#37) O None O Prenatal vitamins O Iron pills O Other vitamins/minerals: _____

O Herbal remedies: O Antacids OLaxatives O Other medicines: _____

88. Any previous breastfeeding experience? O N/A O No O If Yes, how long? _____ O < 1 month

Why did you stop? _____

89. Current infant feeding plans: O Breast O Breast & Formula O Formula O Undecided

90. **Nutrition Assessment Summary** O 24 hour recall O Food frequency (7 days)

a) Food Group	Servings/ Points	Suggested Changes		Food Group	Servings/ Points	Suggested Changes	
Protein		+ -		Vit. A-rich fruit/veg		+ -	
Milk products		+ -		Other fruit/veg		+ -	
Breads/cereals/grains		+ -		Fats/Sweets		+ -	
Vit. C-rich fruit/veg		+ -					

O Referred to Registered Dietitian

b) Diet adequate as assessed: O Yes O No **c) Excessive** O Caffeine (#38)

Completed by: _____

Title: _____ Minutes: _____

Facility: _____ Telephone: _____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

DIETARY INTAKE EVALUATION **(Assessment of the Perinatal Food Frequency Questionnaire)**

GROUP	FOOD	POINTS NEEDED	SERVINGS/DAY	MAJOR NUTRIENTS
1	PROTEINS	21	3	PROTEIN, IRON, ZINC
2	MILK	21	3	CALCIUM, PROTEIN, VITAMIN D
3	BREADS, GRAINS	49	7	CARBOHYDRATES, B VITAMINS, IRON
4	FRUITS/VEGETABLES	7	1	VITAMIN C, FOLIC ACID
5	FRUITS/VEGETABLES	7	1	VITAMIN A, FOLIC ACID
6	FRUITS/VEGETABLES	21	3	CONTRIBUTES TO INTAKE OF VITAMINS A & C
OTHER	FATS AND SWEETS	N/A	3	VITAMIN E

Refer to Protocols for instructions on completing the dietary assessment using the point system above.

90. **(continued)**

14-27 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**			
Protein		+	-		
Milk products		+	-		
Breads/cereals/grains		+	-		
Vit. C-rich fruit/veg		+	-		
Vit. A-rich fruit/veg		+	-		
Other fruit/veg		+	-		
Fats/Sweets		+	-		

b) **Diet adequate as assessed**: O Yes O No

c) **Excessive:** O Caffeine (#38)
O Referred to Registered Dietitian

28-40 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**			
Protein		+	-		
Milk products		+	-		
Breads/cereals/grains		+	-		
Vit. C-rich fruit/veg		+	-		
Vit. A-rich fruit/veg		+	-		
Other fruit/veg		+	-		
Fats/Sweets		+	-		

b) **Diet Adequate as assessed:** O Yes O No

c) **Excessive:** O Caffeine (#38)
O Referred to Registered Dietitian

14-27 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. gain: _____ (61) Protein: - +

O Adequate Ketones: - +

O Inadequate Blood drawn: date: _____

O Excessive Hgb: ___ Hct: ___ MCV: ___

28-40 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. _____ (61) Protein: - +

O Adequate Ketones: - +

O Inadequate Blood drawn: date: _____

O Excessive Glucose____ Hgb: ___Hct: ___ MCV: ___

91. O 3 Hr GTT: Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ O N/A (1 Hr < 140 dl/ml.)

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

92. Are you on any special diet? 14-27 weeks: O No O If Yes, please explain: _____

28-40 weeks; O No O If Yes, please explain: _____

93. Have your eating habits changed since you've been pregnant?

14-27 wks: O No

O If Yes, how: O Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

O Eat less: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

28-40 wks: O No O If Yes, how: O Eat more: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

O Eat less: O Vegetables O Fruit O Protein O Milk O Bread O Other: _____

Coping Skills

94. Are you currently having problems/concerns with any of the following? (check all that apply)

	0-13 wks:	14-27 wks:	28-40 wks:
None	O	O	O
Divorce/separation	O	O	O
Recent death	O	O	O
Illness (TB, cancer, abn. pap smear)	O	O	O
Unemployment	O	O	O
Immigration	O	O	O
Legal	O	O	O
Probation/parole	O	O	O
Child Protective Services	O	O	O

Other: _____ Other: _____ Other: _____

95. What things in your life do you feel good about? _____

_____

96. What things in your life would you like to change? _____

97. What do you do when you are upset? _____

_____

_____

98. In the past month, how often have you felt that you could not control the important things in your life? O No

O Very often O Often O Sometimes O Rarely O Never

99. Have you ever attended group or individual meetings for emotional support or counseling?

O If Yes, when and why? _____

O Yes Have you ever been prescribed drugs for emotional problems? O What? _____ O No

O Yes Have you ever been hospitalized for emotional problems? O What year? _____ O No

100. What do you do when you and your partner have disagreements? _____

101. Does your partner or other family member(s) use drugs and/or alcohol? O No O If Yes, does this create problems for you?

O No O If Yes, Please explain: _____

102. Do you ever feel afraid of, or threatened by your partner? O No O If Yes, Please explain: _____

_____

Pt. Name _____

Date of Birth _____

Health Plan: _____

Identification No.: _____

103. Within the last year have you been hit, slapped, kicked, choked or physically hurt by someone? ↙ O No
O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

104. Since you have been pregnant, have you been hit, slapped, kicked, choked or physically hurt by someone? ↙

0-13 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

105. Within the last year has anyone forced you to have sexual activities? ↙ O No O If Yes, by whom (circle all that apply)

0-13 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: O No O If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

106. Are your children, or have your children ever been, a victim of violence or sexual abuse? ↙ O No
O If Yes, please explain: _____

107. Would you feel comfortable talking to a counselor if you had a problem? O No O Yes

Initial Assessment Completed by:

Name and Title Initials Date Minutes

Second Trimester Reassessment Completed by:

Name and Title Initials Date Minutes

Third Trimester Reassessment Completed by:

Name andTitle Initials Date Minutes

Pt. Name _____
Date of Birth _____
Health Plan: _____
Identification No.: _____

Instructions For Assessment of Prenatal Weight Gain

1. Find the Woman's Weight Category

- Measure her height without shoes.

- Ask the woman her weight before pregnancy (*known* as *pre-pregnancy weight*). If she does not know her pre-pregnancy weight, refer to health care provider and /or calculate the pre-pregnancy weight (see separate instructions).

- Find the woman's height on Table 1 and follow across the row to find her pre-pregnancy weight.

- The title of the column with her pre-pregnancy weight tells you her **weight category** *and also the woman's "Body Mass Index"* ***(BMI) range.***

  Example:
  A woman is 5 feet 2 inches tall. She weighed 145 pounds before pregnancy.
  Her **weight category** is Overweight . . . Her **BMI range** = 25-29.9.

2. Find the Recommended Range and Rate of Weight Gain

- Find the Recommended Weight Gain Range for her weight category on Table 2.

- Research has shown that there is insufficient data to recommend rate of weight gain for the 1st trimester.

- Find the recommended 2nd/3rd trimester rate of gain per month for her weight category.

  Example:
  An Overweight woman should gain 15 to 25 pounds.
  A weight gain of 2 pounds per month is recommended during the 2nd and 3rd trimester.

3. Find the Right Weight Gain Grid

- The weight gain grid is a tool that helps you see if the woman is gaining within the recommended range.

- Choose the grid that matches her weight category. *There are* ***four*** *weight gain grids:* Underweight, Normal Weight, Overweight, and Obese**.** Document the pre-pregnancy weight and height on the correct grid.

- **The Weight Gain Grid:**
  - The ***horizontal zero line*** starts at conception.
  - The ***vertical zero line*** represents the woman's weight before pregnancy.
  - Each horizontal line above the zero represents one pound *gained.*
  - Each horizontal line below the zero represents one pound *lost.*
  - Each vertical line represents one more week into the pregnancy (gestational age).

4. Plot the Weight Gain Grid

- **Note:** Record the woman's pre-pregnancy weight on the appropriate weight grid.

- If she does not know her pre-pregnancy weight, document the weight that was estimated or calculated.

- Take the woman's weight today and substract it from her pre-pregnant weight. This number equals the number of pounds she has gained (+) or lost (-).

  Example:
  A woman, 5 feet 2 inches weighed 145 pounds before pregnancy.
  At 18 weeks gestation she weighs 151 pounds (lbs).

  (151 lbs.-145 lbs. = 6 lbs.
  She gained 6 lbs.

  - Find the line that marks her weight change and the line that marks the number of weeks of gestation.

  - Mark an **X** where these two lines meet.

  - Check to see whether her total weight gain at this visit falls within her target weight gain range. In this example she is within the range for overweight women.

  -

- Plot weight gain at **each prenatal** visit. ***Always subtract the pre-pregnant weight from today's weight***.

- Show the woman where her weight is on the grid. Discuss her weight gain progress.

5. What the Weight Gain Grid Tells You

- The weight gain grid can tell you if the woman is gaining too fast, too slow, or just right. The pattern of weight gain is as important as the total gain.

- The grid is also a screening tool to identify women who need more in-depth assessment and counseling.

- When a woman's gain is outside the recommended range, assess factors that may affect her weight gain. See "*Low Weight Gain"* and "*High Weight Gain"* in the Nutrition section of Steps to Take Guidelines.

  Some women may not follow the curves of the Weight Gain Grid or may be four or five pounds above or below the recommended line even though they are eating a nutritious diet. Other women may be eating too little or too much. It is important to find out what the woman is eating. Follow the guidelines for the Perinatal Food Frequency Questionnaire (PFFQ).
  (A 24-hour food recall is also an acceptable dietary assessment tool, but is not recommended unless the assessor has received adequate training.)

Steps to Take for Appropriate Weight Gain

- **If the woman is gaining above or below the recommended range, complete the Perinatal Food Frequency Questionnaire (or 24-Hour Food Recall) monthly.**

  Emphasize the Daily Food Guide for Pregnancy whether or not the pregnancy weight gain fits the recommended weight gain grid.

- **If she is not eating enough or eating too much** in any of the food groups, discuss with the woman the changes she needs to make in her diet.

  Make a plan together that will bring about positive changes.

- **If her weight gain is within the recommended range**, assess her diet.

  If her diet is fine, congratulate the woman and encourage her to continue eating well.

  Review her diet intake each month and her weight at **each prenatal** visit.

- **If her weight gain is below the recommended range**, review "*Low Weight Gain*" in the Nutrition section of Steps to Take Guidelines.

  Even if the woman is not eating enough of certain foods, look for other factors which may also explain the low weight gain.

- **If her weight gain is above the recommended range**, review "*High Weight Gain*" in the Nutrition section of Steps to Take Guidelines.

  Do not restrict the diets of women who are gaining extra weight when they consume low fat foods within the recommended number of food groups.

  Even if the woman is eating too much of certain foods, look for other factors which may also explain her excess weight gain.

- **Continue to monitor weight gain at each prenatal visit.**

Reference:
Adapted from Steps to Take, Comprehensive Perinatal Services Program – Program Guidelines for Enhanced Health Education, Nutrition, and Psychosocial Services, Steps to Take Guidelines, 1997 Edition, CDHS.

Table 1: Weight Categories for Women According to Height and Pre pregnancy Weight *

Height	Under Weight **(BMI - < 18.5)**	Normal Weight **(BMI 18.5 – 24.9)**	OverWeight **(BMI 25-29.9)**	Obese Weight **(≥ 30)**
4’ 7”	< 80	80 -107	108-128	>128
4’ 8”	< 83	83 -111	112-133	>133
4’ 9”	< 86	86 -115	116-138	>138
4’10”	< 89	89 -119	120-143	>143
4’11	< 92	92 -123	124-148	>148
5’ 0”	< 95	95 -127	128-153	>153
5’ 1”	< 98	98 -132	133-158	>158
5’ 2”	<101	101-136	137-163	>163
5’ 3”	<105	105-140	141-169	>169
5’ 4”	<108	108-145	146-174	>174
5’ 5”	<111	111-149	150-179	>179
5’ 6”	<115	115-154	155-185	>185
5’ 7”	<118	118-159	160-191	>191
5’ 8”	<122	122-164	165-196	>196
5’ 9”	<125	125-168	169-202	>202
5’10”	<129	129-173	174-208	>208
5’11”	<133	133-178	179-214	>214
6 ’0”	<137	137-183	184-220	>220
6’ 1”	<140	140-189	190-227	>227
6’ 2”	<143	143-194	195-233	>233
6’ 3”	<148	149-199	200-239	>239

Table 2: Recommended Range and Rate of Weight Gain

* Recommended - Weight Gain Range Twins	Underweight 28 - 40 lbs. N / A	Normal Weight 25 - 35 lbs. 37–54 lbs.	Overweight 15 – 25 lbs. 31–50 lbs	Obese 11 – 20 25-42 lbs.
** Recommended Rate of Weight Gain /mo.				
*** 1st Trimester	------	------	------	------
2nd /3rd Trimester	4lbs.ormore	3-4 lbs.	about 2 lbs.	varies

***** -** IOM, 2009. Weight Gain During Pregnancy: Reexamining the Guidelines. Washington, DC: National Academies Press.

** - Steps to Take, Comprehensive Perinatal Services– Program Guidelines for Enhanced Health Education, Nutrition, and Psychosocial Services, Step to Take Guidelines, 1997 Edition, CDHS.

*** - Research to date concludes that there is insufficient data for recommendation for rate of weight for the 1st trimester.

INSTRUCTIONS
WHEN PRE-PREGNANCY WEIGHT IS NOT KNOWN

At the first visit:

1. Estimate the woman's pre-pregnancy status (*underweight, normal weight, overweight or obese weight*) by considering her current height and weight. If uncertain, consider her to be within the normal range.

2. Determine the week of gestation at the time of the current weight.

3. Place a dot on the grid where the line representing the week of gestation crosses the lower line of the weight gain range estimated to be appropriate for the woman.

4. Subtract the number of pounds represented by the line at the dot from the current weight to determine an estimated pre-pregnancy weight. Record this estimated pre-pregnancy weight on the appropriate weight gain grid, noting that it is "*estimated"*, or "*calculated*".

   Example:
   Pre-pregnancy Weight = Est. 150 lbs. - **or** Pre-pregnancy Weight = Calc.150 lbs.

When future weight measurements are available:

1. Determine the number of pounds gained or lost by comparing the current weight with the estimated pre-pregnancy weight.

2. Determine the week of gestation on the date of the current weight.

3. Place a dot on the grid where the line representing the number of pounds gained or lost crossed the line representing the week of gestation.

4. Compare the change in weight between measurements with the gain expected for the estimated pre-pregnancy status (*underweight, normal weight, overweight, or obese*).

5. Consider the results of this assessment with the results of the dietary and clinical (physical/medical) assessment to determine appropriate recommendations.

Reference:
Adapted from Maternal and Child Health Branch, WIC Supplemental Food Branch, California State Department of Health Services, Prenatal Weight Gain Grid, June 1991.

Rev. 6/9/10

Prenatal
Weight Gain Grids*

1. Pre-pregnancy Under Weight Range

2. Pre-pregnancy Normal Weight Range

3. Pre-pregnancy Over Weight Range

4. Pre-pregnancy Obese Weight Range

* Based on IOM (Institute of Medicine) 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, D.C. National Academies Press.

Name:

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
4'7"	< 80	80-107	108-128	> 128
4'8"	< 83	83-111	112-133	> 133
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5'5"	< 111	111-149	150-179	> 179
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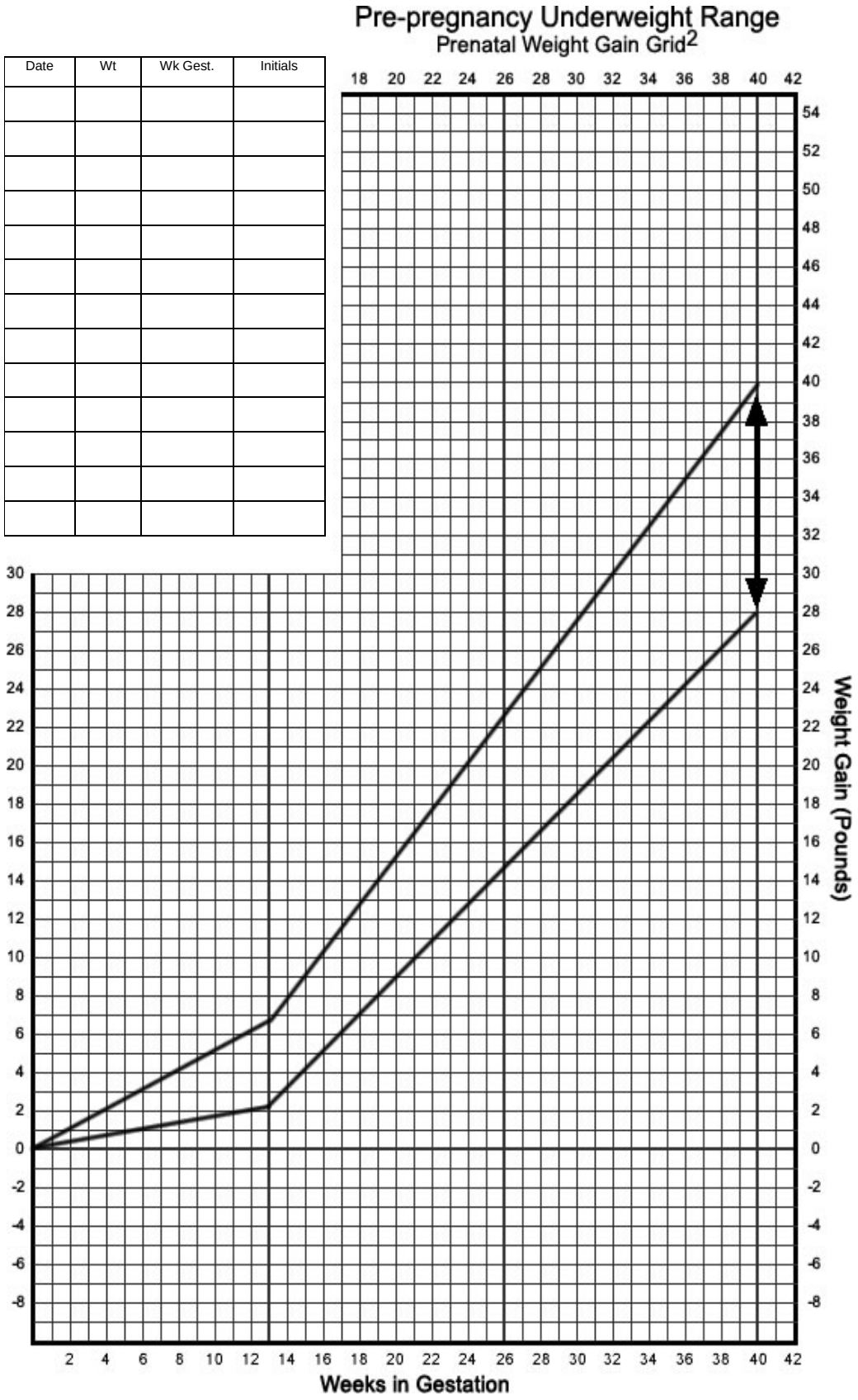
6'3"	< 148	149-199	200-239	> 239

BMI = Weight (lbs.)/Height (in.)² X 703

Date	Wt	Wk Gest.	Initials



Recommended Weight Gain[1]:

Mark One:		Single	Twins
☐	Underweight	**28-40 lbs.**	N/A
☐	Normal	**25-35 lbs.**	37-54 lbs.
☐	Overweight	**15-25 lbs.**	31-50 lbs.
☐	Obese	**11-20 lbs.**	25-42 lbs.

Pre-pregnancy Weight: _____

Height: _____

[1] IOM, 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines.* Washington, DC: National Academies Press.

[2] Per Personal Communication with the Committee to Reexamine IOM Pregnancy Weight Guidelines

Name:

Weight Categories for Women According to Height and Pre-pregnancy Weight (lbs)[1]:

Height	Under Weight (BMI <18.5)	Normal Weight (BMI 18.5-24.9)	Over Weight (BMI 25-29.9)	Obese (BMI ≥ 30)
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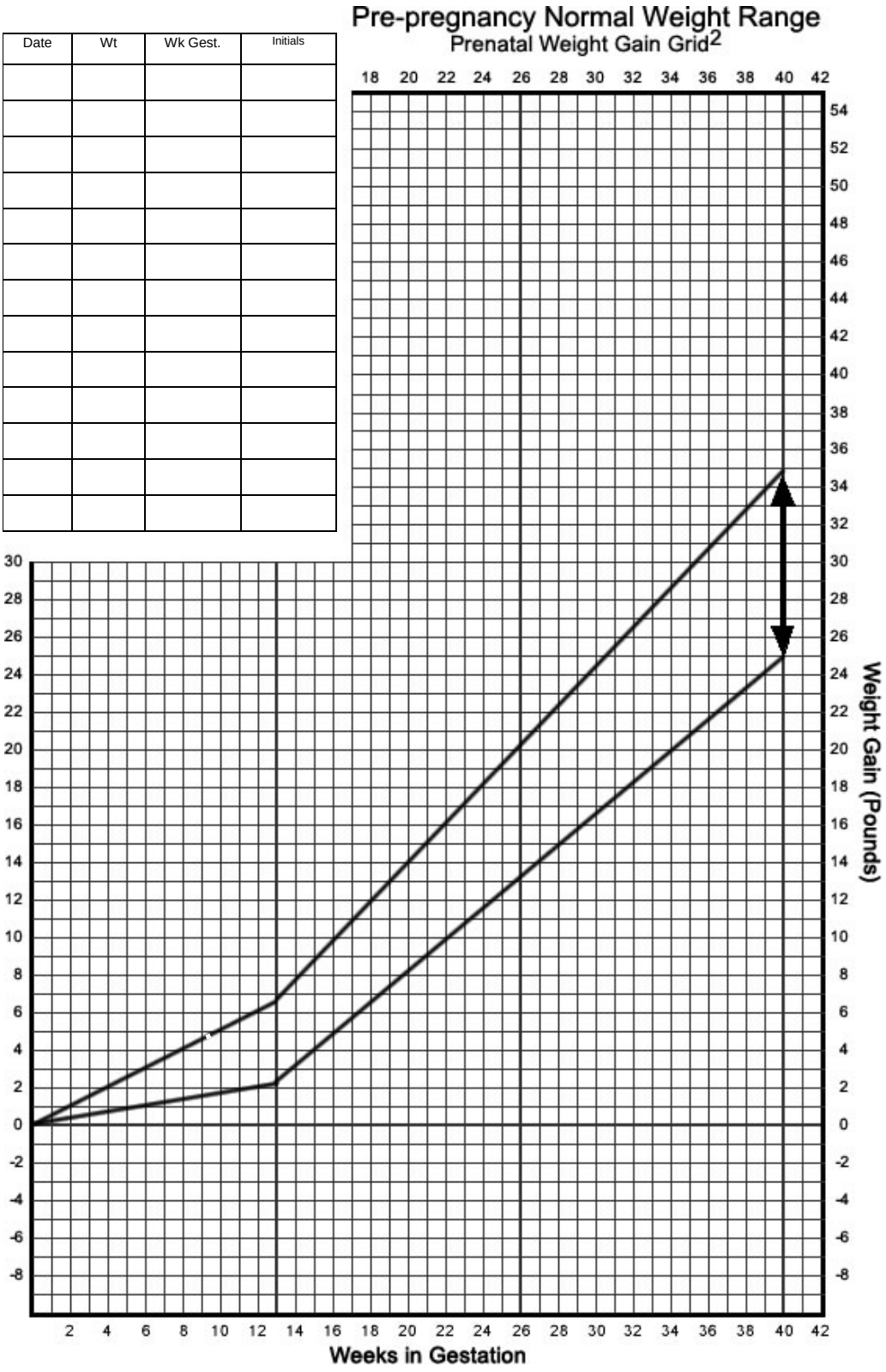

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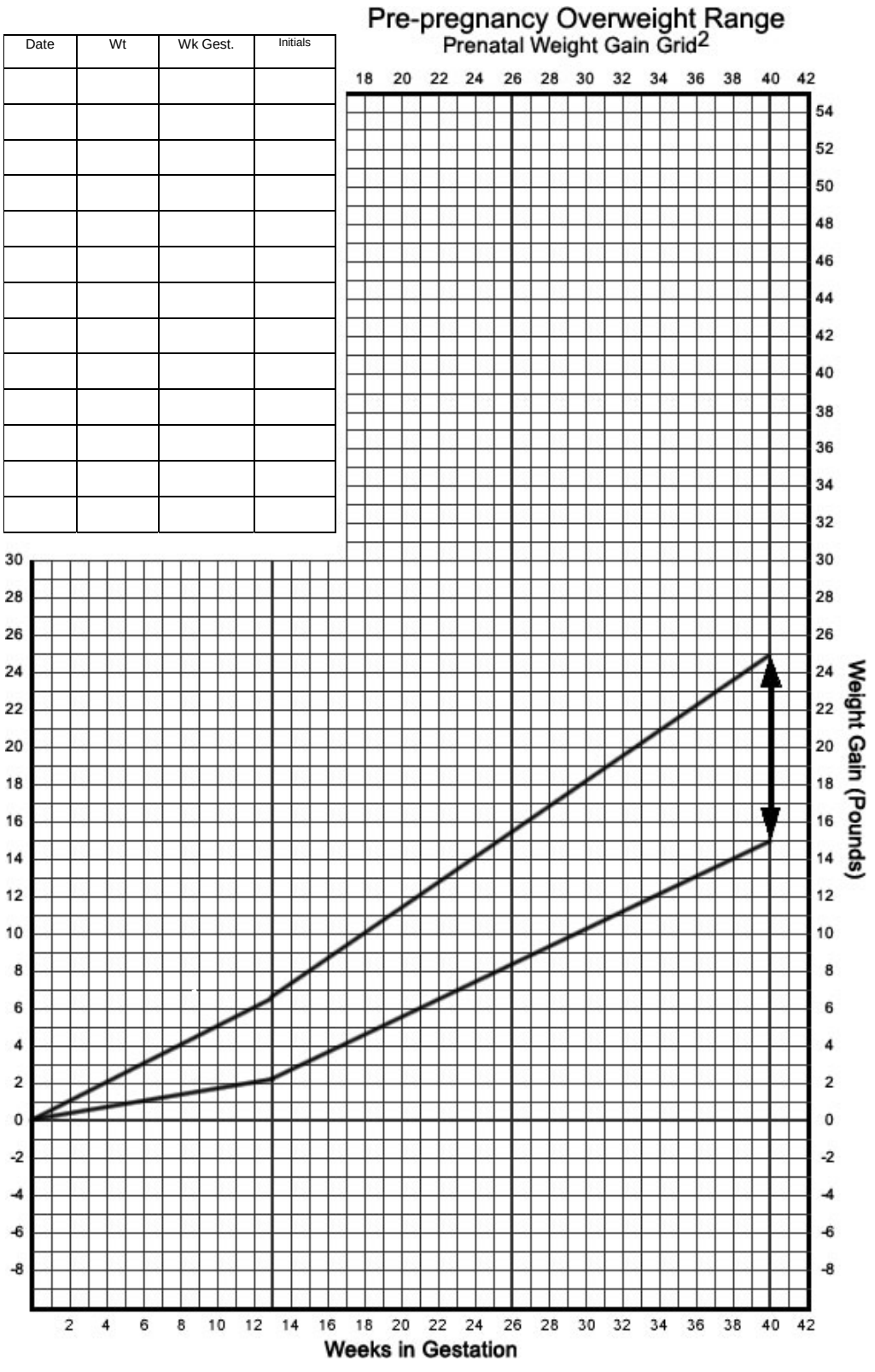

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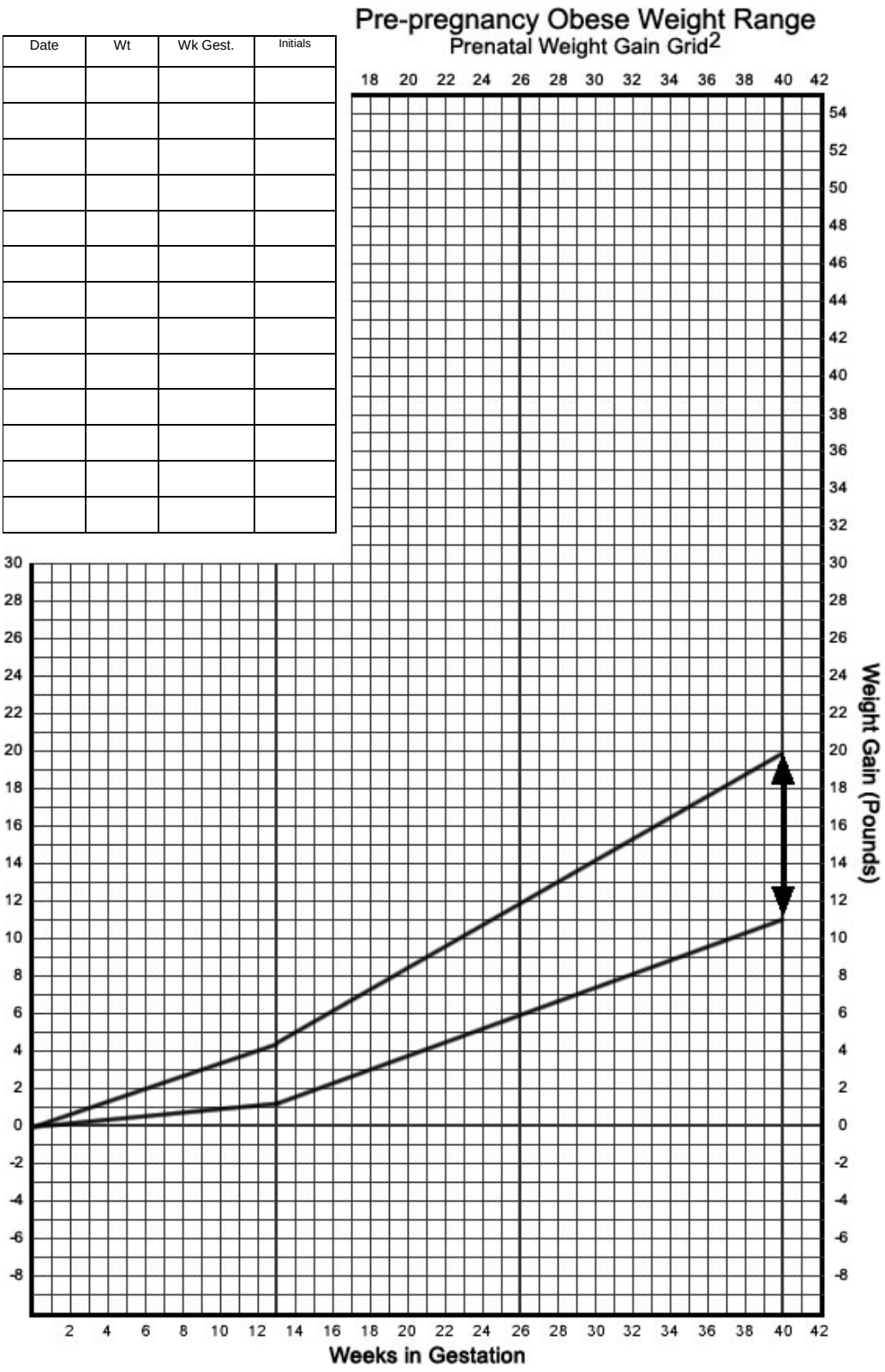

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Pre-pregnancy Weight: _____

Height: _____

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CPSP Nutrition Steps to Take Guidelines
BMI and Interventions

	UNDERWEIGHT <18.5	NORMAL 18.5 – 24.9	OVERWEIGHT 25 - 29.9	OBESE ≥ 30
	• *(Prepregnant weight is below normal for height.)* • Possible results: greater chance of having a: • Preterm birth. • Small unhealthy baby. * Recommended weight gain: 28 to 40 pounds	*(Prepregnant weight is normal for height.)* Possible results: greater chance of • Giving birth at term (37 weeks or more). • Having a healthy baby weighing more than 5.5 pounds. * Recommended weight gain: 25 to 35 pounds	*(Prepregnant weight is over normal for height.)* Possible results: greater chance of having • A baby who weighs more than 9 pounds • More problems with delivery. * Recommended weight gain: 15 to 25 pounds	*(Prepregnant weight is obese for height.)* Possible results: greater chance of having • A baby who weighs more than 9 pounds. • More problems with delivery. * Recommended weight gain: 11- 20 pounds
Steps To Take	• Provide advice to relieve discomforts of pregnancy if any are present. • Explain how to follow the *Daily Food Guide for Pregnancy.* Emphasize extra servings from each group. • Stress the importance of regular meals and snacks. • Recommend a weight gain of at least 4 pounds or more each month. • Explain the importance of gaining 28 to 40 pounds.	• Provide advice to relieve discomforts of pregnancy if any are present. • Explain how to follow the *Daily Food Guide for Pregnancy.* • Advise her to eat regular meals and snacks. • Recommend gaining about 3 to 4 pounds per month after her 16th week. • Explain the importance of gaining 25 to 35 pounds	• Provide advice to relieve discomforts of pregnancy if any are present • Explain how to follow the *Daily Food Guide for Pregnancy*. Highlight the low-fat choices from each of the groups. • Recommend regular meals and snacks. • Recommend a weight gain of about 2 to 3 pounds per month after the 16th week. • Explain importance of gaining 15 to 25 pounds.	• Provide advice to relieve discomforts of pregnancy if any are present. • Explain how to follow the *Daily Food* • *Guide for Pregnancy*. Emphasize use of low-fat choices and portion size control. • Stress importance of regular meals and snacks. • Recommend a weight gain of 2 ½ pounds per month after the 16th week. • Explain the importance of gaining 11-20 pounds.
Follow-Up	• Check weight gain and rate of gain at each prenatal visit. Plot on Weight Gain Grid. • If weight gain is too low, discuss the handout, *Tips to Gain Weight.*	• Check weight gain and rate of gain at each prenatal visit. Plot on *Weight Gain Grid.* • If weight gain is too low, discuss, *Low Weight Gain* and the Nutrition handout ***Tips** to **Gain Weight.*** • If weight gain is too high, discuss, *High Weight Gain* and the Nutrition handout, *You Can Slow Weight Gain.*	• Check weight gain and rate of gain at each prenatal visit. Plot on *Weight Gain Grid.* • If weight gain is too low, discuss Low Weight Gain and the Nutrition handout *Tips to gain weight.* • If weight gain is too high, discuss *High Weight Gain* and the Nutrition handout, *You can slow weight gain.*	• Check weight gain and rate of gain at each prenatal visit. Plot on Weight Gain Grid. • If weight gain is too low, discuss *Low Weight Gain* and the Nutrition handout *Tips to Gain Weight.* • If weight gain is too high, discuss Height Weight Gain and the Nutrition handout: *You can slow gain weight.*
Referral	Refer to health care provider and registered dietitian if: • Weight loss of more than 4 pounds in the first 12 weeks of pregnancy. • No weight gain *by 16 weeks.* • Weight gain is less than 14 pounds at 24 weeks. • Gain of less than 3 pounds in any single month after 14 weeks.	Refer to health care provider and registered dietitian if: • Weight loss of more than 5 pounds in the first 12 weeks of pregnancy. • No weight gain by 16 weeks. • Weight gain is less than 12 pounds at 24 weeks. • Gain of more than 6.5 pounds in any month. • Gain of less than 2 pounds in any single month after 14 weeks.	Refer to health care provider and registered dietitian if: • Weight loss of more than 5 pounds in the first 12 weeks of pregnancy. • No weight gain by 20 weeks. • Weight gain is less than 8 pounds at 26 weeks. • Gain of less than 2 pounds in single month after 14 weeks. • Gain of more than 6.5 pounds in any month	Refer to health care provider and registered dietitian if: • Weight loss of more than 8 pounds in the first 12 weeks of pregnancy. • No weight gain by 20 weeks. • Gain of more than 6.5 pounds in any single month after 14 weeks. • Gain of less than 1 pound in any single month after 14 weeks.

*** Current research suggests that the optimal gestational weight gain might be ***lower*** than the Institute of Medicine (IOM) recommendations for all maternal BMI categories, especially among ***obese women*.**

Revised - 2/2010

Reference Source: Steps to Take: Comprehensive Perinatal Services Program , Nutrition Program Guidelines, 1997 Edition , and

*Daily Food Guide for Pregnant/Breastfeeding Women (All Ages) 6

Food Groups	One Serving Equals		Recommended Minimum Servings
Protein Foods Provide protein, iron, zinc, and B-vitamins for growth of muscles, bone, blood, and nerves. Vegetable protein provides fiber to prevent constipation.	**Animal Protein:** 2-3oz Cooked chicken, turkey, lean beef, lamb, pork, or fish. 2 Eggs 2 Fish sticks or hot dogs 2 slices luncheon meat ¼ cup canned tuna or other canned fish	**Vegetable Protein:** ½ cup cooked dry beans, lentils or split peas 3 oz Tofu ¼ cup nuts or seeds 2 tbsp. peanut butter	**3** Include one serving of vegetable protein daily.
Milk Products Provide protein and calcium to build strong bones, teeth, healthy nerves and muscles, and to promote normal blood clotting.	8 oz milk or yogurt 1 cup milk shake 1½ cup cream soup (made with milk) 1½ oz or 1/3 cup grated cheese (like cheddar, Monterey, mozzarella, or Swiss)	1½ -2 slices pre-sliced American cheese 4 tbsp. parmesan cheese 2 cups cottage cheese 1 cup pudding, custard or flan 1½ cups ice milk, ice cream, or frozen yogurt	**3**
Breads, Cereals & Grains Provide carbohydrates and vitamins for energy and healthy nerves. Also provide iron for healthy blood and fiber to prevent constipation.	1 slice bread or dinner roll ½ bun, bagel, English muffin or pita 1 small tortilla ¾ cup dry cereal ½ cup cooked cereal or granola	½ cup rice, noodles or spaghetti ¼ cup wheat germ 1 4-inch pancake or waffle 1 small muffin 8 medium crackers 4 graham cracker squares 3 cups popcorn	**7** Four servings of whole-grain products daily
Vitamin C-Rich Fruits and Vegetables Provide vitamin C to prevent infection and to promote healing and iron absorption. Also provide fiber to prevent constipation.	6 oz orange, grapefruit, or fruit juice enriched with vitamin C 6 oz tomato juice or vegetable juice cocktail 1 orange, kiwi, mango ½ grapefruit, cantaloupe ½ cup papaya 2 tangerines	½ cup strawberries ½ cup cooked or 1 cup raw cabbage ½ broccoli, Brussels sprouts, or cauliflower, snow peas, sweet peppers, or tomato puree 2 tomatoes	**1**
Vitamin A-rich Fruits and Vegetables Provide beta-carotene and vitamin A to prevent infection and promote wound healing and night vision. Also provide fiber to prevent constipation.	6 oz apricot nectar, or vegetable juice cocktail 3 raw or ¼ cup dried apricots ¼ cantaloupe or mango 1 small or ½ cup sliced carrots 2 tomatoes	½ cup cooked or 1 cup raw spinach ½ cup cooked greens (beet, chard, collards, dandelion, kale, mustard) ½ cup pumpkin, sweet potato, winter squash, or yams.	**1**
Other Fruits & Vegetables Provide carbohydrates for energy and fiber to prevent constipation.	6 oz fruit juice (if not listed above) 1 medium or ½ cup sliced fruit (apple, banana, peach, pear) ½ cup berries (other than strawberries) ½ cup cherries, grapes, pineapple or watermelon	¼ cup dried fruit ½ cup sliced vegetable (asparagus, beets, green beans, celery, corn, eggplant, mushrooms, onion, peas, potato, summer squash, zucchini) ½ artichoke 1 cup lettuce	**3**
Unsaturated Fats Provide vitamin E to protect tissue.	1/8 medium avocado 1 tsp. margarine, mayonnaise or vegetable oil	2 tsp. salad dressing (mayonnaise-base) 1 tbsp. salad dressing (oil based)	**3**

Note: The Daily Food Guide for Women may not provide all the calories you require. The best way to increase your intake is to include more than the minimum servings recommended.

*-Adapted for LAC/DHS-CPSP Trainings

INSTRUCTIONS FOR THE PERINATAL FOOD FREQUENCY QUESTIONNAIRE

The Perinatal Food Frequency Questionnaire (PFFQ) is used to determine the different foods a patient eats each day or week. This dietary information is used together with anthropometric (height/weight), biochemical (labs), and clinical information to complete the nutrition component of the Prenatal Initial Combined Assessment/Reassessment Tool (ICA).

FOOD INTAKE & FREQUENCY

A nutrition assessment needs to be completed on every woman, initially and at least once each trimester, *using a Perinatal Food Frequency Questionnaire*. The questionnaire will help the evaluator:

- assess the patient's nutritional status;
- compare what and how much she eats to the *Daily Food Guide* recommendations*;*
- help her find foods she enjoys in food groups where she doesn't eat enough; and
- learn about her food habits, culture, family, and lifestyle

HOW TO DO A PERINATAL FOOD FREQUENCY QUESTIONNAIRE - (PFFQ)

The Perinatal Food Frequency Questionnaire (PFFQ) uses the seven food groups from the *Daily Food Guide for Women*. Foods are grouped according to similar nutrients and one food can be exchanged for another within the same group. Eating the recommended number of servings in groups 1-6 assures that a pregnant or breastfeeding woman will eat at least 90% of the Recommended Dietary Allowances (RDA) for protein, vitamins, and minerals. Eating the recommended servings in the "Other Foods" group (identified with the triangle ▲ symbol), assures appropriate intake of unsaturated fats and vitamin E.

Either the client or evaluator can complete the questionnaire. The client instructions are at the top of the page of the PFFQ. **Note:** although it states "*if you eat the food less than 1* time *per week, do not mark columns*," this information must be reviewed and totaled by the evaluator who should fill in any blanks with a *"0"*. The "Other Foods" group is not scored, but is evaluated to capture the intake of unsaturated fats.

Record the final scores of the PFFQ in question #90 of the ICA- "Nutrition Assessment Summary". ***A completed PFFQ is also required for each trimester reassessment and postpartum assessment and must remain in the chart.*** Completing a PFFQ takes practice. Speed and accuracy will come as more questionnaires are completed.

The PFFQ uses a ***point system*** to determine if the diet is adequate. The points in the *bottom left corner* of each box – in parentheses - are equal to the recommended number of servings in the Daily Food Guide multiplied by 7 ***(1 serving equals 7 points).*** For example: In Group 1 (Protein), a patient needs 21 points. This is equal to 3 "servings." ***Follow the Steps Below:***

1. Explain what you are going to do:

"I am going to read off a list of foods. For each food tell me the number of times you eat that food every day. If you do not eat that food daily, tell me how many times you eat that food each week."

2. Fill out the PFFQ:

As you read off the foods, write in the client's answers. If she eats the food every day, write down her answer in the **Daily** column. If she does not eat a food every day, write down her answer in the **Weekly** column. If she eats the food less than one time per week, document a zero.

3. Score the PFFQ:

After filling out the answers for all the food groups, go back and add up the totals for groups 1-6. For each group:

a Add all the numbers in the **Daily** column and write that number on the **Subtotals** line, to the left of "___ x 7=". Multiply this number by 7 and write in the total to the right of the "x 7 =____ ".

b Add all the numbers in the **Weekly** column and write that total on the **Subtotals** line.

c Add the subtotals from the **Daily** column and **Weekly** column. Write the total on the last line next to **Total Points.**

4. **Discuss the changes she should make to her diet:**
Review each food group and provide suggestions to help client meet her needs. Use the following information to help evaluate her needs:

a Compare the **Total Points** of each group with the **Recommended Points** (found in *parentheses* in the lower left corner of each box (*shaded area*).

b If the **Recommended Points** are greater than the **Total Points,** the client is not meeting her minimum needs for that group. To advise her on how many servings to add to her daily diet **subtract** the **Total Points** from the **Recommended Points** and divide the answer by 7. This number is the number of servings from that group the client needs to add to her diet every day.

* The diet is low in total protein only if the combined points of groups 1 and 2 are less than 35.

***** A star (*****) next to a food indicates that this food is high in folate. A diet may be low in folate if the total for all starred foods is less than 7.

***** A triangle (▲) next to a food indicates that it is high in unsaturated fats. A diet may be low in unsaturated fats if the total intake is less than 3.

c If the **Total Points** is greater than the **Recommended Points** you will need to evaluate whether a decrease in servings is necessary. (Remember that the

Recommended Points is the minimum number suggested: a greater intake may be encouraged.) Use the following guidelines to advise the client:

Groups 1 & 2:
Encourage client to eat the lower fat sources from these groups (chicken, fish and beans from Group1; low-fat/nonfat dairy from Group 2). Determine whether a high intake of foods from these groups interferes with an adequate intake from other groups. If intake from these groups is very high, suggest replacing some servings from these groups with servings from the other groups that are deficient.

Group 3:
Encourage client to eat whole grains. Remind client to limit high fat additions to foods, like butter, margarine, or cream sauces. Determine whether a high intake of foods from this group interferes with an adequate intake from other groups. If intake from this group is very high, suggest replacing some servings from this group with servings from the other groups that are deficient.

Groups 4, 5, & 6:
A high intake from these groups should be encouraged. Remind client to eat a variety of foods from each group. Be sure fruit intake includes both juices and whole fruits. Remind client to limit intake of fried vegetables and limit higher fat additions to vegetables, like butter, cheese, or cream sauces.

"Other Foods" Group:
This group is not scored, but is important to evaluate the intake of unsaturated fats. In general, more than 3 servings per day of foods that are high in fat or sugar may lead to excess weight or displacement of more nutritious foods.

It is recommended that fat be limited to the items indicated with the triangle (▲), which are high in unsaturated fat. Encourage clients to eat these foods in moderation. Determine whether a high intake of foods from this group interferes with an adequate intake from other groups. If intake from this group is very high, suggest replacing some servings from this group with servings from groups that are deficient. Check the client's weight. If she is overweight, or if she is gaining weight too quickly, advise her to limit these foods. If she is underweight, or if she is gaining weight too slowly, advise her to eat adequate amounts from all the food groups, and then add these extra foods.

Incorporating PFFQ Information Into Initial Combined Assessment/Reassessment Tool

The PFFQ information needs to be transferred to the "Nutrition Assessment Summary" section (question #90) of the ICA. Transfer the **Total Points** from each food group (1-6) to the corresponding food group line in question # 90. (Remember to put a check ☑ in the box for "Food Frequency (7 days)" to indicate that you used a PFFQ rather than a 24-hour diet recall. Circle the word **"points"** in **Part a** "Food Group"/ column 2 "Servings/Points."

1. If **Recommended** Points are greater than **Total Points**:

    1. Subtract **Total Points** from **Recommended Points**.
    2. Divide this total by 7. Write this number in the column under **"Suggested Changes"**
    3. Circle the "+" sign under **"Suggested Changes."**

3. If the **Total Points** are greater than **Recommended Points**:

    a. Subtract **Recommended Points** from **Total Points**.
    b. Divide this total by 7. Write this number in the column under **"Suggested Changes"**
    c. Circle the "-" sign under **"Suggested changes."**

4. Complete **Part b** for initial assessment.

5. Repeat above steps for each reassessment and postpartum visit.

DIETARY ASSESSMENT SUMMARY

This section must be completed by the Evaluator for the Initial Combined Assessment (ICA), and for 2nd and 3rd trimester reassessments, and for postpartum assessment.

- Diet Inadequate/Excessive In:

Compare actual points with recommended points. Note which food groups/nutrients are inadequate or excessive and list them in appropriate areas. For initial assessment, transfer this information to the *"Nutrition Assessment Summary" of the ICA.*

- Comments /Needs:

Note any pertinent findings from Food Groups 1-6 and "Other Foods". This information may be useful in development of the Individualized Care Plan (ICP).

- Nutrition Intervention:

Summarize what you have done for the woman by checking the appropriate intervention(s) as follows:

>check when you have completed counseling for identified problems; check if you have given a brochure (*you may note which one*); check if you have referred high risk patients to the Registered Dietitian (R.D.) per protocols.

Sign and date tool; record the woman's name and ID/chart information.

Note: A 24-hour diet recall may be used instead of a Food Frequency Questionnaire, but the provider must demonstrate that staff have been adequately trained and knowledgeable in its use.

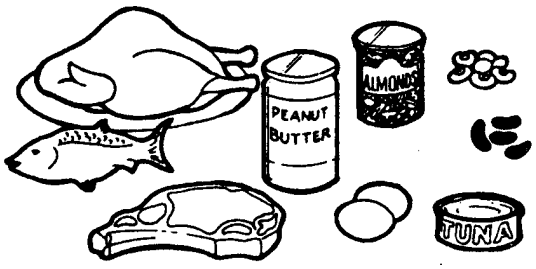
Please check one:
_Initial Assessment
_ 2nd Trimester Reassessment
_ 3rd Trimester Reassessment
_ Postpartum Assessment

Client Name:
I.D. Number:

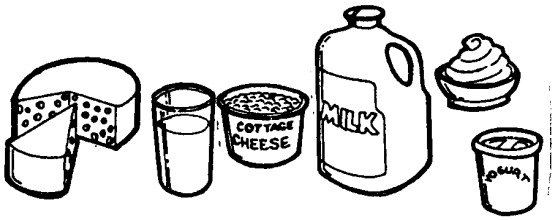
PERINATAL FOOD FREQUENCY QUESTIONNAIRE
(PFFQ)

(Client Instructions)
How often do you eat the food listed below?
If you eat the food every day, mark the number of times per day in the daily column.
If you eat the food one or more times per week (not every day), mark the number of times per week in the weekly column.
If you eat the food less than once per week. do not mark columns.

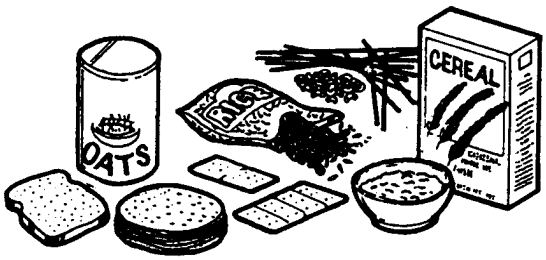
Group 1	Daily	Weekly
Meat/ carne		
Chicken/ pollo		
Fish/pescado		
shell fish/marisco		
Eggs/huevos		
*beans/frijoles		
peanut butter/creama de cacahuate		
Subtotals:	x7=	+
(21)		Total Points:



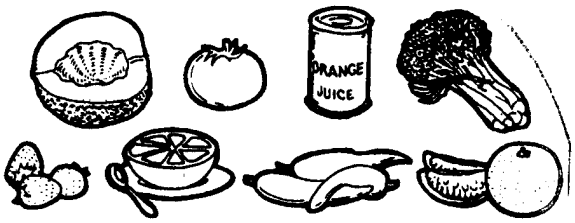
Group 2	Daily	Weekly
Milk/leche		
Cheese/queso		
Yogurt/yogur		
Subtotals:	x7=	+
(21)		Total Points:



Group 3	Daily	Weekly
Bread/pan (1 slice)		
tortilla (1)		
cooked cereal/ cereal, cocida		
dry cereal/cereal seca		
Rice/arros		
pasta		
Subtotals:	x7=	+
(49)		Total Points:

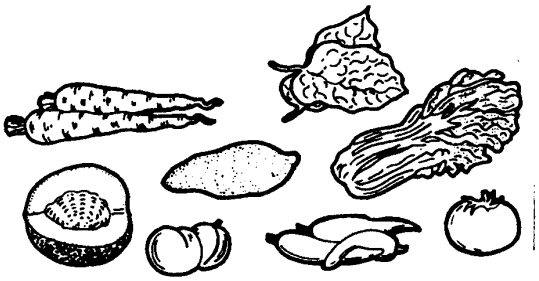


Group 4	Daily	Weekly
*orange/naranja		
*orange juice/jugo De naranja		
*tomato/tomate		
Cabbage/col repollo		
*broccoli/brocoli		
*cauliflower/coliflor		
Subtotals:	x7=	+
(7)		Total Points:

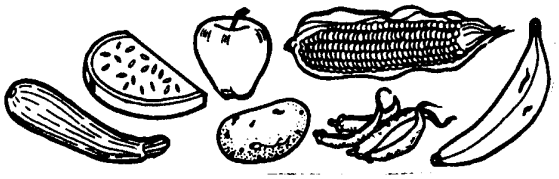


Client Name:
I.D. Number:

Group 5	Daily	Weekly
*spinache/greens Espinaca/hojas de verde		
sweet potato/camote		
Carrots/zanahoria		
Cantaloupe/melon		
mango		
Subtotals:	x7=	+
(7)		Total Points:



Group 6	Daily	Weekly
Apple/manzana		
Banana/platano		
pineapple juice/ jugo de pina		
Corn/elote		
Lettuce/lechuga		
potatoes (white)/ papas (blancas)		
Zucchini/calabazita		
other fruits & vegetables/otras frutas y verduras		
Subtotals:	x7=	+
(21)		Total Points:



Other Foods	Daily	Weekly
fried foods /comidas firtas		
Butter/manteguilla		
▲ margarine /margarina		
sour cream/crema agria		
▲ mayonnaise/ mayonesa		
▲ salad dressing/ Salad para ensalada		
▲ vegetable oil/ Aceite vegetal		
▲ avocado/ aquacate		
Chips/papitas		
Donuts/		
Candy/ Carmelo/chocolate		
soda		
other sugar drinks/ bebidas con azucar		
Other sweets/ otros dulces		

DIETARY ASSESSMENT SUMMARY

Diet Inadequate In:
(food groups/nutrients)

Diet Excessive In:

Comments/Needs:

☐ Brochures Given

☐ Referred to Nutritionist

Name and Title of Evaluator/ Date

_____

STATE OF CALIFORNIA
BCIA 8583
(orig. 6/05; rev 3/08)

DEPARTMENT OF JUSTICE

CHILD ABUSE OR SEVERE NEGLECT INDEXING FORM

Print Form | Reset Form

To be completed by Submitting Child Protective Agency pursuant to Penal Code section 11169

☐ **INITIAL REPORT**

☐ **AMENDED REPORT (attach copy of original BCIA 8583. Complete sections A, C, and all other applicable fields)**

A. SUBMITTING AGENCY

SUBMITTING AGENCY (Enter complete name and check type)	☐ POLICE ☐ SHERIFF	☐ WELFARE ☐ PROBATION	AGENCY REPORT NUMBER/CASE NAME	
AGENCY ADDRESS Street	City		State	Zip Code
NAME OF SUBMITTING PARTY	TITLE		AGENCY TELEPHONE	

B. INCIDENT INFORMATION

DATE OF REPORT	The finding that allegations of child abuse or severe neglect are not unfounded is: (Check only one box) ☐ SUBSTANTIATED (Penal Code section 11165.12(b)) ☐ INCONCLUSIVE (Penal Code section 11165.102(c))
DATE OF INCIDENT	TYPE OF ABUSE (Check one or more) ☐ PHYSICAL INJURY ☐ MENTAL/EMOTIONAL SUFFERING ☐ SEXUAL ABUSE, ASSAULT, EXPLOITATION ☐ SEVERE NEGLECT ☐ WILLFUL HARMING/ENDANGERMENT ☐ UNLAWFUL CORPORAL PUNISHMENT OR INJURY

C. AMENDED REPORT INFORMATION

Original Agency Report Number/Case Name: ________ Date of Incident: ________ Type of Abuse: ________

☐ CHANGED TO INCONCLUSIVE ☐ ADDED ADDITIONAL INFORMATION
☐ CHANGED TO SUBSTANTIATED ☐ CORRECTED REPORT INFORMATION
☐ NOW UNFOUNDED ☐ UNDERLYING INVESTIGATIVE FILE NO LONGER AVAILABLE

Comment:

D. INVOLVED PARTIES

VICTIM(S)

NAME: Last First Middle	AKA	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
DID VICTIM'S INJURIES RESULT IN DEATH? ☐ YES ☐ NO ☐ UNKNOWN	IS VICTIM DEVELOPMENTALLY DISABLED (4512(a) W&I)? ☐ YES ☐ NO ☐ UNKNOWN			
NAME: Last First Middle	AKA	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
DID VICTIM'S INJURIES RESULT IN DEATH? ☐ YES ☐ NO ☐ UNKNOWN	IS VICTIM DEVELOPMENTALLY DISABLED (4512(a) W&I)? ☐ YES ☐ NO ☐ UNKNOWN			
NAME: Last First Middle	AKA	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
DID VICTIM'S INJURIES RESULT IN DEATH? ☐ YES ☐ NO ☐ UNKNOWN	IS VICTIM DEVELOPMENTALLY DISABLED (4512(a) W&I)? ☐ YES ☐ NO ☐ UNKNOWN			

SUSPECT(S)

NAME: Last First Middle				AKA				DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
ADDRESS Street	City	State	Zip Code	HGT	WGT	EYES	HAIR	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER		
RELATIONSHIP TO VICTIM: ☐ PARENT/STEPPARENT ☐ SIBLING ☐ OTHER RELATIVE ☐ FRIEND/ACQUAINTANCE ☐ STRANGER											
NAME: Last First Middle				AKA				DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
ADDRESS Street	City	State	Zip Code	HGT	WGT	EYES	HAIR	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER		
RELATIONSHIP TO VICTIM: ☐ PARENT/STEPPARENT ☐ SIBLING ☐ OTHER RELATIVE ☐ FRIEND/ACQUAINTANCE ☐ STRANGER											

OTHER

NAME: Last First Middle	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
NAME: Last First Middle	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
NAME: Last First Middle	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *
NAME: Last First Middle	DOB	Approx. AGE	☐ MALE ☐ FEMALE	RACE *

*** RACE CODES:**

W - White
B - Black
H - Hispanic
I - American Indian
F - Filipino
P - Pacific Islander
C - Chinese
J - Japanese
A - Other Asian
Z - Asian Indian
D - Cambodian
G - Guamanian
U - Hawaiian
K - Korean
L - Laotian
S - Samoan
V - Vietnamese
O- Other
X - Unknown

☐ **CHECK HERE IF ADDITIONAL SHEET(S) ATTACHED**

FOR DOJ USE ONLY

RCN

AGY

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (4/1/09)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – **NO P.O. Box)** City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

GOVERNOR'S OFFICE OF CRIMINAL JUSTICE PLANNING

SUSPICIOUS INJURY REPORT

OCJP-920 (NEW 11/03)

STATE OF CALIFORNIA

Go to Form OCJP-920

Instructions To The Health Practitioner

Penal Code Section 11160 *mandates* the following regarding suspicious injuries:

- Internal procedures established to facilitate reporting and apprise supervisors and administrators of reports shall be consistent with the reporting requirements of PC Section 11160. The internal procedures shall not require any employee who must make a report to disclose his or her identity to the employer.
- Report suspicious injuries to your local law enforcement agency by telephone **immediately**, or as soon as practically possible.
- Submit the required completed written report to your local law enforcement agency *within two working days of discovering a suspicious injury,* whether or not:
  1. The person has expired;
  2. The injury was a factor contributing to the person's death; or
  3. Evidence of the conduct of the perpetrator is discovered during an autopsy.
- Use this standard form or a form, developed and adopted by another state agency, that otherwise fulfills the requirements of this form, (see "Exceptions to using this form" below).
- Two or more health practitioners with knowledge of a suspicious injury may mutually select a team member to make the telephone report and one written report signed by the selected team member. A team member who knows that the selected team member has not made the telephone call or submitted the written report shall make the report(s).
- No supervisor or administrator shall impede or inhibit the required reporting duties, and no person making a report pursuant to this section shall be subject to any sanction for making the report.

Exceptions To Using This Form

Other state reporting mandates pre-empt the use of this form to report suspicious injuries, as follows:

Incident	Form	Source of Form
Physical Child Abuse	SS 8572	Call California Department of Justice at (916) 227-3285.
Dependent Adult / Elder Abuse	SOC 341	Online: http://www.dss.cahwnet.gov/pdf/SOC341.pdf or contact your local County Adult Protective Services Dept.
Sexual Assault – Adult*	OCJP 923*	Online: www.ocjp.ca.gov/publications.htm or call OCJP at (916) 324-9100.
Sexual Assault – Child*	OCJP 925* OCJP 930*	

*Use these forms to conduct a forensic examination of the victim. Otherwise, use this Suspicious Injury Report form.

Definitions

Health Practitioner – Provides medical services to a patient for a physical condition that he/she reasonably suspects is a suspicious injury as listed below, and is employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.

Suspicious Injury – Includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury is by means of a firearm, OR
- Is suspected to be the result of *assaultive or abusive conduct* inflicted upon the injured person.

Injury – Shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

Assaultive / Abusive Conduct – includes committing, or an attempt to commit, any of the following Penal Code violations:

- Abuse of spouse or cohabitant
- Aggravated mayhem
- Administering controlled substances or anesthetic to aid in the commission of a felony
- Assault with a stun gun or taser
- Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
- Assault with intent to commit mayhem, rape, sodomy, or oral copulation
- Battery
- Child abuse or endangerment (including Statutory Rape)
- Elder abuse
- Incest
- Lewd and lascivious acts with a child
- Murder
- Manslaughter
- Mayhem
- Oral copulation
- Procuring any female to have sex with another man
- Rape
- Sexual battery
- Sexual penetration
- Sodomy
- Spousal rape
- Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure
- Torture

When Sexual Intercourse* with a Minor Must Be Reported as Child Abuse: California Law

In California, health care practitioners are mandated to report any reasonable suspicion of child abuse. Sexual intercourse with a minor is reportable as child abuse *when*:

1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report any intercourse that was coerced or in any other way not voluntary, irrespective of the ages of the partners and even if both partners are the same age. Sexual activity is not voluntary, for example, when accomplished against the victim's will by means of force or duress, or when the victim is unconscious or so intoxicated that he or she cannot resist. *See* Penal Code § 261 for more examples. Irrespective of what your patient tells you, treating professionals should use clinical judgment and "evaluate facts known to them in light of their training and experience to determine whether they have an objectively reasonable suspicion of child abuse." 249 Cal. Rptr. 762.

2. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND PATIENT IN A FEW SITUATIONS

Mandated reporters also must report based on the age difference between the patient and his or her partner in a few circumstances, according to the following chart:

KEY: M = *Mandated. A report is mandated based solely on age difference between partner and patient.*
CJ = *Clinical Judgment. A report is not mandated based solely on age; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that act was coerced, as described above.*

Age of Partner ⇒	12	13	14	15	16	17	18	19	20	21	22 and older
Age of Patient ⇓											
11	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
12	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
13	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
14	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
15	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
16	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
17	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
18	M	M	CJ	CJ	CJ	CJ					
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	CJ	CJ					

Chart design by David Knopf, LCSW, UCSF.
(*The legal sources for this chart are as follows*: Penal Code §§ 11165.1; 261.5; 261; 259 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1st Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1st Dist. Ct. App. 1998).

Do I have a duty to ascertain the age of a minor's sexual partner for the purpose of child abuse reporting?

No statute or case obligates health care practitioners to ask their minor patients about the age of the minors' sexual partners for the purpose of reporting abuse. Rather, case law states that providers should ask questions as in the ordinary course of providing care according to standards prevailing in the medical profession. Thus, a provider's professional judgment determines his practice. 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988).

What do I do if I am not sure whether I should report something?

When you aren't sure whether a report is required or warranted, you may consult with Child Protective Services and ask about the appropriateness of a referral.

*This worksheet addresses reporting of consensual vaginal intercourse between **non-family members**. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California and other states, check www.teenhealthrights.org

County of Los Angeles Public Health
Maternal, Child & Adolescent Health Programs

MENTAL HEALTH RESOURCES AND CRISIS HOTLINES

If you need help right away or think you might hurt yourself, your baby, or someone else.	**CALL 911**
Suicide Prevention Center Help available 24 hours a day, 7 days a week.	1 (800) 784-2433 or 1 (877) 727-4747
ACCESS Line Los Angeles County Mental Health phone referral services available 24 hours a day, 7 days a week.	1 (800) 854-7771
211 Los Angeles Information Line Available 24 hrs a day, 7 days a week. Ask operator for maternal depression resources in your area.	Dial 211
National Depression Hot Line Available 24 hrs a day, 7 days a week for information and referrals to mental health providers.	1 (800) 773-6667
National Hispanic Perinatal Help Line Available 6am-3pm: provides education and referrals to mental health providers.	1 (800) 504-7081 www.hispanichealth.org
Postpartum Support International English and Spanish Help Line that offers support, education, and local resources.	1 (800) 944-4PPD www.postpartum.net
Project Cuddle, Inc. 24-hour crisis hotline: assistance, support, transport to medical appointments, etc. Provides pregnant women alternatives to abandoning babies.	Crisis Number: 1-88TO CUDDLE 1 (888) 628-3353 www.projectcuddle.org

Los Angeles County Department of Mental Health	www.dmh.lacounty.gov
The Marce Society International research society on maternal mental health.	www.marcesociety.com
MedEd PPD English and Spanish postpartum depression education and resources.	www.mededppd.org/sp/
Medline Plus Health Information English and Spanish health information.	www.nlm.nih.gov/medlineplus/postpartumdepression.html
Postpartum Depression Online Support Group Information, support, and assistance for those dealing with postpartum mood disorders.	www.ppdsupportpage.com
Postpartum Progress Blog on depression and anxiety during pregnancy and postpartum.	www.postpartumprogress.typepad.com
Postpartum Dads Information and guidance through the experience of postpartum depression.	www.postpartumdads.org
Child Abuse Hot Line To report suspected child abuse. Social Workers are also available 24/7 for consult.	1 (800) 540-4000
Dependent Abuse Hot Line To report suspected abuse on the elderly or dependent adults.	1 (877) 477-3646

Individualized Care Plan (ICP)

Patient:_____ Gravida: ____ Para:_____ EDC:_____

Provider Name: _____Case Coordinator Name: _____

Provider's Signature:_____ Date: _____

Date: _____ Strengths Identified:	Identified Problem/ Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan
Date: _____ Strengths Identified:	Goal:			

First initial, last name, title and date required with every entry.
May be used in conjunction with, or without a standardized prenatal/postpartum education/services checklist.
Address obstetrical, nutrition, psychosocial, and health education problems/needs.

Pt. name:
DOB:
Health Plan:
I.D.#:

Individualized Care Plan

Patient: _____ I.D. # : _____
Provider Signature: _____

Date: _____ Strengths Identified:__	Identified Problem /Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan
Date: _____ Strengths Identified:__	Identified Problem /Risk/Concern _____ Goal:	Teaching/ Counseling/ Referral _____	Follow-up Reassessment Date- Outcome/Plan	Follow-up Reassessment Date- Outcome/Plan

First initial, last name, title and date required with every entry.
May be used in conjunction with, or without a standardized prenatal/postpartum education/services checklist.
Address obstetrical, nutrition, psychosocial, and health education problems/needs.

Pt. name:
DOB:
Health Plan:
I.D.#:

Individualized Care Plan

Keypoints for the Individualized Care plan

- The ICP must be developed in conjunction with the patient.
- For each identified problem develop a goal with the patient.
- Be sure to reinforce strengths with the patient in order to increase her self-esteem.
- Use identified CPSP problem list when developing a plan.
- Each problem must have a plan of proposed interventions.
- The plan includes interventions which are appropriate and are not in conflict with the patient's status, needs or wishes.
- The interventions may include action taken by CPSP staff or referrals to outside agencies.
- Referrals to outside resources should include name of agency, contact person and telephone number.
- The interventions should include persons responsible, methods, time frame, and outcome objectives.
- Clearly document when the intervention was done.
- The plan for high-risk patient may need to be further described in a progress note.
- Update plan with current changes throughout the pregnancy.
- The ICP should be utilized in case conferences.

COMPREHENSIVE PERINATAL SERVICES PROGRAM
COMBINED POSTPARTUM ASSESSMENT

Name:_____ **DOB:**_____ **Date:** _____ **I.D. No.**_____

Health Plan:_____ **Provider:** _____ **Delivery Facility:** _____

Anthropometric:

1. Height ____ 2. Desirable Body Wt. _____ 3. Total Pregnancy Wt. Gain _____ 4. Wt. this visit _____

5. Prepregnant wt. ____ 6. Postpartum Wt. Goal _____ 7. Weeks Postpartum this Visit _____

Biochemical:

Blood: Date Collected: _____

8. Hemoglobin: ____ (<10.5) 9. Hematocrit: ____ (<32) Other: _____

Urine: Date Collected: _____

10. Glucose: + - 11. Ketones: + - 12. Protein: + - Other: _____

13. Blood Pressure: ____ / ____ Comments: _____

Clinical - Outcome of Pregnancy:

14. Date of Birth: _____ 15. Gestational Age: ____ 16. Pregnancy/Delivery Complications:

17. Birth Weight:(gms) ____ 18. Birth Length (cm): ____

19. Current Weight: (gms) ____ 20. Current Length(cm): ____ Apgar Scores: 1 min: 5 min:

21. Type of Delivery: (circle) NSVD VBAC Vacuum Forceps C-Section (Primary or Repeat) (LTCS or Classical)

Maternal:

22. Have you had your postpartum check up? oYes Date:

oIf No, when scheduled? _____

23. Any health problems since delivery? oYes oNo

If **YES**, please explain: _____

Infant:

24. Has infant had a newborn check-up?

If No, when scheduled? _____

If Yes, any Problems? _____

25. Number of NICU Days: _____

26. Infant exposure to: (circle all that apply)

Tobacco Alcohol Drugs

Nutrition:

27. **Maternal Dietary Assessment:** For ____ Day(s)

Food Group	Servs./ Points		Suggested Change
Protein	____	+ -	____
Milk Products	____	+ -	____
Breads/Cereals/Grains	____	+ -	____
Vit. C-rich fruit/veg	____	+ -	____
Vit. A-rich fruit/veg	____	+ -	____
Other fruit/veg	____	+ -	____
Fats/Sweets	____	+ -	

Dietary Goals:

Client agrees to:

REFERRALS: o WIC Date Enrolled: _____

o Food Stamps o Emergency Food o AFDC

Diet adequate as assessed: o Yes o No Excessive: o Caffeine

28. **Infant**

Method of Feeding: o Breast o Bottle o Breast & Bottle # Wet diapers/day? ____

Type of Formula: ____ With Iron? o Yes o No ____ oz.. ____ times/day

Psycho-Social

29. Do you feel comfortable in your relationship with your baby? O Yes ONo _____
    Any special concerns? _____
30. Are you experiencing post-partum blues? OYes ONo _____
31. Have your household members adjusted to your baby? OYes ONo _____
32. Has your relationship with the baby's father changed? OYes ONo _____
33. Do you have the resources to assist in maximizing the health of you and your baby? OYes ONo
    If "No", indicate where needs exist: OHousing OFinancial OFood OFamily O Other: _____
34. Outstanding issues from Prenatal Assessment/Reassessment: _____

Health Education

35. If breast feeding:
    Do you have enough milk? OYes ONo
    * Do you supplement with formula? OYes ONo
    Does your baby take the breast easily? OYes ONo
    Are your nipples cracked and/or sore? OYes ONo
    Do you have any questions about breast feeding? OYes ONo
36. Do you have any questions about mixing or feeding formula? OYes ONo
37. Do you have any questions about your baby's health? OYes ONo
    If "Yes", please explain: _____
38. Do you have any questions about your baby's safety? OYes ONo
    If "Yes", please explain: _____
39. Are you using, or planning to use, any method of birth control? OYes ONo
    If "Yes", which one? _____
    If "No", would you like further information? _____

Plan:

Client Goals, Interventions and Timeline

Client agree to:

Referrals

Agency:_____ Date:_____ Agency:_____ Date:_____

Materials Given:

O	Birth Control	O	Infant Feeding	O	Infant Care	O	Infant Safety	O	_____
O	_____	O	_____	O	_____	O	_____	O	_____

Summary:

Date:_____ Interviewer:_____ Title_____ Minutes Spent:____

Copy of Individualized Care Plan sent to Patient's PCP on: (date) _____ by: (name and title)_____

Maternal Child Adolescent Health Programs
COMPREHENSIVE PERINATAL SERVICES PROGRAM
Documentation Guidelines

The purpose of this section is to provide guidance to Comprehensive Perinatal Services Program (CPSP) providers regarding documentation of services provided and billed to Medi-Cal. These guidelines are complementary to other resources and rules regarding the CPSP requirements in statute, regulations, billing manuals, and Medi-Cal Services bulletins; these guidelines do not supersede the other requirements.

It is hoped that the CPSP Documentation Guidelines will assist providers in reducing billing problems and meeting program requirements. These Guidelines may be used by the Department of Health Services auditors in addition to the other documents mentioned above.

Basic Principles for CPSP Billing

All Services billed must be:

1. Provided by a Department of Health Services certified Comprehensive Perinatal Service Provider;
2. Provided in direct patient contact before they are billed;
3. Billed in accordance with the appropriate procedure codes;
4. Documented in writing. If there is no documentation, the assumption is that no services was given;
5. Patient services as specified in the CPSP regulations;
6. In accordance with the instructions in the Medi-Cal Training Syllabus for Medi-Cal obstetrics (OB/CPSP); and
7. Submitted no later than six months subsequent to the month in which the CPSP services was provided or in accordance with State Law.

CPSP BILLING INFORMATION

BONUSES

EARLY ENTRY INTO CARE (Z1032-ZL) - If the patient receives her initial pregnancy-related exam within 16 weeks LMP (anytime up to 16 weeks), add modifier -ZL to the Initial Pregnancy-Related exam code Z1032 and add $56.63 to your "usual and customary fees" for this service. Maximum allowance for Z1032-ZL is $182.94 ($126.31 + $56.63).

Billing ZL Modifier when done by Non-Physician Medical Practitioner (multiple Modifier):

CNM bills 99: SB+ ZL
NP bills 99: SA+ ZL
PA bills 99: U7+ ZL

10TH ANTEPARTUM VISIT (Z1036) - may be billed one time only when the 10th antepartum visit is provided. Medi-Cal reimburses non-CPSP providers for the initial prenatal visit and 8 antepartum visits (9 visits total). CPSP providers are able to bill for one additional visit. Reimbursement is $113.26.

CPSP SUPPORT SERVICES

Support services (health education, nutrition, and psychosocial) are billed in 15 minute units. A minimum of 8 minutes of service must be provided in order to bill.

UNITS	TIME (Minutes)	RANGE (Minutes)
1	15	8-22
2	30	23-37
3	45	38-52
4	60	53-67

Formula for determining time range is as follows:

Range = Time ± 7 minutes

Example: 3 units = 45 minutes (3 x 15 min.)
45 minus 7 = 38 minutes
45 plus 7 = 52 minutes
Range for 3 units = 38-52 minutes

Key Points for Support Services Documentation

- All entries should be written legibly in black ink.
- Be sure all blanks are filled in. If the question doesn't apply, write "N/A" for "Not Applicable."
- If the patient did not want to answer the question, make a brief note on the form, such as "patient declines."

- Use only abbreviations that are approved for use at your site.
- If an error is made, a single line with black ink should be drawn through the incorrect information, leaving the original writing legible, marked "error" and initialed and dated by the person who made the original entry. DO NOT attempt to erase, block out or use "white out."
- DO NOT alter another person's note under any circumstances

- All entries should be dated and signed with the first initial, last name and title.
- Time spent in minutes should be noted at the end of the assessment; indicated only time spent face to face with the patient, not time spent on phone calls, charting, etc. unless the patient is present during these activities.
- Each page contains a patient identifier, such as full name, birth date and medical record number.

- All referrals, including name of agency, contact person and phone numbers should be recorded in the chart.

CLASS SIGN-IN SHEET

TITLE:

____

INSTRUCTOR: ______________________________ ______________________________
(Name) (Signature)

DATE: ________________________ **TIME SPENT (in minutes):** ________________

NAME	**PATIENT RECORD NUMBER**

Summary of CPSP Medi-Cal Billing

Name: _____ **D.O.B.:** _____ **MR#:** _____

CPSP Patient Billing	Billing Code	Number of Units Used (1 Unit = 15 Minutes) *Please Initial and Date Each Unit Used per Visit*
Obstetrical (# Visits)		
Initial Antepartum	**Z1032**	
16 Weeks Early Entry LMP Bonus	**ZL**	**Use with Z1032 only up to 16 0/7ths LMP**
Antepartum 8 visits	**Z1034**	1 2 3 4 5 6 7 8
10th Antepartum (only CPSP)	**Z1036**	**After initial visit and 8 antepartums**
Postpartum	**Z1038**	
Prenatal Vitamins (# 30 per unit)	**S0197**	1 2 3 4 5 6 7 8 9 10
CPSP Services		
Initial Comp Assess.	**Z6500***	*** All 3 completed within 4 weeks of initial visit (Z1032)**
1. Health Education 30 Min	*Date:*	
2. Nutrition 30 Min	*Date:*	
3. Psychosocial 30 Min	*Date:*	
Nutrition		
Initial Assessment - Ind 30 min	**Z6200**	**Don't use if Z6500 billed**
Additional Init Assess - 1.5 hrs	**Z6202**	1 2 3 4 5 6
F/U Interven/Reasses - Ind 2 hrs	**Z6204**	1 2 3 4 5 6 7 8
F/U Intervention - Group 3 hrs	**Z6206**	1 2 3 4 5 6 7 8 9 10 11 12
Postpartum - Ind 1hr	**Z6208**	1 2 3 4
Psychosocial		
Initial Assessment - Ind 30 min	**Z6300**	**Don't use if Z6500 billed**
Additional Init Assess 1.5 hrs	**Z6302**	1 2 3 4 5 6
F/U interven/Reassess - Ind 3 hrs	**Z6304**	1 2 3 4 5 6 7 8 9 10 11 12
F/U Intervention - Group 4hrs	**Z6306**	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
Postpartum - Ind 1.5 hrs	**Z6308**	1 2 3 4 5 6
Health Education		
Client Orientation - Ind 2 hrs	**Z6400**	1 2 3 4 5 6 7 8
Initial Assessment - Ind 30 min	**Z6402**	**Don't use if Z6500 billed**
Additional Init Asses. 2 hrs	**Z6404**	1 2 3 4 5 6 7 8
F/U Interven/Reassess - Ind 2 hrs	**Z6406**	1 2 3 4 5 6 7 8
F/U Ed Assess /Interv Grp 2 hrs	**Z6408**	1 2 3 4 5 6 7 8
Perinatal Education - Ind 4hrs	**Z6410**	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
Group Education 18 hrs	**Z6412**	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72
Postpartum - Ind 1 hr	**Z6414**	1 2 3 4

Service Codes and Reimbursement Schedule

The following are the Comprehensive Perinatal Provider service codes effective August 1, 2000 for Nutrition, Health Education, and Psychosocial services.

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
Z6500 [2]	Initial Comprehensive Nutrition, Psychosocial, and Health Education Assessments and Development of Care Plan within 4 weeks of entry into care [3], Individual, first 30 minutes of each Assessment (90 minutes total), including ongoing coordination of care. Initial Pregnancy-related exam (Z1032) must also be completed within this 4-week period.	Initial CPSP Assessment completed within 4 weeks of Initial Prenatal Exam (Z1032). This 90 minutes is for Health Educ., Nutrition, and Psychosocial initial assessment time only - does not include Client Orientation.	1	$135.83	$135.83
NUTRITION CODES					
Z6200	Initial Nutrition Assessment and Development of Care Plan, Individual, first 30 minutes.	For first 30 minutes of Initial Nutrition Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6202	Initial Nutrition Assessment and development of Care Plan, Individual, each Subsequent 15 minutes (Maximum of 1 1/2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in nutrition component (either Z6500 or Z6200 used); 2) An Entirely new problem@ diagnosed later in pregnancy requiring a new nutrition assessment, e.g. gestational diabetes.	6	$8.41	$50.46
Z6204	Follow-up Antepartum Nutrition Assessment, Treatment, and/or Intervention, Individual, each 15 minutes	Trimester reassessments; antepartum counseling, such as by RD consultant.	8	$8.41	$67.28

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	(Maximum of 2 hours)				
Z6206	Follow-up Antepartum Nutrition Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes (Maximum of 3 hours)	Nutrition information provided in a group class.	12	$2.81	$33.72
Z6208	Postpartum Nutrition Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum nutrition assessment; 2) Postpartum nutrition intervention, e.g. assistance with breastfeeding	4	$8.41	$33.64
S0197	Prenatal Vitamins, 30 day supply	When provider dispenses prenatal vitamins	10	$3.00	$30.00
PSYCHOSOCIAL CODES					
Z6300	Initial Psychosocial Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of Initial Psychosocial Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6302	Initial Psychosocial Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 1 1/2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in psychosocial component (either Z6500 or Z6300 used); 2) An Entirely new problem@ diagnosed later in pregnancy requiring a new psychosocial assessment, e.g. domestic violence.	6	$8.41	$50.46
Z6304	Follow-up Antepartum Psychosocial Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 3 hours)	Trimester reassessment; antepartum counseling or other intervention, such as by social work consultant.	12	$8.41	$100.92
Z6306	Follow-up Antepartum Psychosocial Assessment, Treatment, and/or Intervention, Group, per patient, each 15	Psychosocial information provided in a group class.	16	$2.81	$44.96

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	minutes (Maximum of 4 hours)				
Z6308	Postpartum Psychosocial Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 11/2 hours)	1) Postpartum psychosocial assessment; 2) Postpartum psychosocial intervention, e.g. postpartum depression	6	$8.41	$50.46
		HEALTH EDUCATION CODES			
Z6400	Client Orientation, Individual, each 15 minutes (Maximum of 2 hours)	Initial individual orientation (required); orientation required during pregnancy, e.g. when patient is referred to hospital for non-stress test.	8	$8.41	$67.28
Z6402	Initial Health Education Assessment and Development of Care Plan, Individual, first 30 minutes	For first 30 minutes of Initial Health Education Assessment when Initial CPSP Assessment not completed within 4 weeks of Initial Prenatal Exam (Z1032).	1	$16.83	$16.83
Z6404	Initial Health Education Assessment and Development of Care Plan, Individual, each subsequent 15 minutes (Maximum of 2 hours)	1) Time spent doing initial assessment exceeded 30 minutes in health education component (either Z6500 or Z6402 used); 2) An Entirely new problem@ diagnosed later in pregnancy requiring a new health education assessment.	8	$8.41	$67.28
Z6406	Follow-up Antepartum Health Education Assessment, Treatment, and/or Intervention, Individual, each 15 minutes (Maximum of 2 hours)	Trimester reassessment; antepartum counseling or other intervention, such as by health education consultant.	8	$8.41	$67.28
Z6408	Follow-up Antepartum Health Education Assessment, Treatment, and/or Intervention, Group, per patient, each 15 minutes	Health education provided in a group class.	8	$2.81	$22.48

Procedure Code	Description	When to Use	Maximum Units of Service	Reimbursement per Unit of Service	Maximum Reimbursement [1]
	(Maximum of 2 hours)				
Z6414	Postpartum Health Education Assessment, Treatment, and/or Intervention, including update of Care Plan, Individual, each 15 minutes (Maximum of 1 hour)	1) Postpartum health education assessment; 2) Postpartum health education intervention.	4	$8.41	$33.64
		PERINATAL EDUCATION CODES (Can be used antepartum or postpartum)			
Z6410	Perinatal Education, Individual, each 15 minutes (Maximum of 4 hours)	Individual education provided prenatally or postpartum.	16	$8.41	$134.56
Z6412	Perinatal Education, Group, per patient, each 15 minutes (Maximum 4 hours/day,18 hours/pregnancy)	Group education, e.g. childbirth education (Lamaze)	72	$2.81	$202.32
		CPSP OB BONUSES			
Z1032-ZL	Initial Comprehensive Pregnancy-related office visit performed within 16 weeks of LMP	Initial prenatal exam done prior to 16 weeks LMP. *If non-physician practitioner (NP, PA, CNM) does exam, see M/C Provider Manual for appropriate modifier.*	1	$56.63	$56.63
Z1036	Tenth Antepartum Office Visit	One time only when 10th antepartum visit performed.	1	$113.26	$113.26

[1] Additional reimbursement is subject to prior approval using a Medi-Cal Treatment Authorization Request (TAR).

[2] If Z6500 is used, codes Z6200, Z6300, and Z6402 cannot be used because the first 30 minutes of each assessment is already included in Z6500. However, additional initial assessment time can be billed under codes Z6202, Z6302, or Z6404.

[3] Entry into care is the time of the first billable pregnancy-related office visit or initial support service assessment.

MCAH Division
Overview of National and State Resources for Electronic Health Record Adoption
Updated March 30, 2011

This document provides an overview of current Federal and State efforts to implement Electronic Health Records (EHRs).

The Office of the National Coordinator is leading Federal efforts to implement Electronic Health Records. The Web site is:
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

The Health Resources and Services Administration has an excellent Web site at http://www.hrsa.gov/healthit/index.html that includes helpful links to:

- EHR selection guidelines
- Webinars
- Regional Extension Centers
- Health IT and Quality
- Toolboxes

The Center for Medicare and Medicaid Services (CMS) is working to encourage providers to adopt EHRs by providing incentives and support to providers and supporting health IT workforce training. The goal is to achieve widespread adoption of EHRs by 2015. CMS adopted the EHR Incentive Rule in July 2010. This rule makes EHR incentives available to Medicare and Medicaid providers, but providers are not required to apply. Information on the EHR incentive program is available at http://www.cms.gov/EHRIncentivePrograms/#BOOKMARK2

Registration for the EHR incentive program began January 3, 2011. Providers may register before they have a system installed. Medicare providers may receive up to $44,000, and Medicaid providers may receive up to $63,750 over 6 years for implementing eligible systems. Providers may receive incentives under only one of the options and may switch programs only one time after they receive the first payment. Eligible professionals may qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use in subsequent participation years to receive additional payments. **The Medicaid incentive program is dependent on individual states.** Medi-Cal is developing a system to manage incentive payments for California's eligible providers. **The most current information specific to California** is available at: http://medi-cal.ehr.ca.gov/ and http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_11790.asp

Eligible EHR systems are listed on the Office of the National Coordinator Web site in a searchable format at: http://onc-chpl.force.com/ehrcert

Eligible systems must enable "meaningful use", which includes:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

For more information on Meaningful Use, review the following Web site:
http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp

To demonstrate that they are meeting meaningful use requirements, providers must demonstrate that they meet the core objectives and must report six quality measures. The core objectives are available at http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

In addition, providers must report three core quality measures and three additional measures that they choose from 38 measures. Specifications for the measures and information on the Quality Incentive Program is available at:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

Core measures are:

1. Blood pressure measurement
2. Tobacco use and intervention
3. Adult weight screening and follow up.

An alternative core measure set is:

1. Weight assessment and counseling for children and adolescents
2. Flu shot for people over 50
3. Childhood immunizations

There are two prenatal care measures that providers may choose from the 38 optional measures:

NQF 0012 **Prenatal Care: HIV Screening**
Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
NQF 0014 **Prenatal Care: Anti-D immune Globulin**
Title: Prenatal Care: Anti-D Immune Globulin Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

Comprehensive Perinatal Services Program (CPSP)
Electronic Health Record Functionality Basics

This document provides information that CPSP providers may want to consider when evaluating Electronic Health Record (EHR) functionality in CPSP practices.

The requirements for CPSP are the same whether a provider has electronic or paper records. These requirements are listed in Title 22 of the California Code of Regulations, and interpreted in the CPSP Provider Handbook, Steps to Take Guidelines, and each provider's protocols. It is important that the EHR facilitate the CPSP work flow in each provider office. Each provider should evaluate the content and functionality of the EHR system. The County Perinatal Services Coordinator (PSC) can assist by reviewing the EHR content using an approved set of CPSP forms as a guide. If a CPSP provider implements a CPSP EHR that is not functional, it may be difficult to conduct quality assurance (QA) to assure implementation of CPSP in accordance with Title 22. Forms that are scanned into an EHR will not allow sufficient functionality to meet federal Meaningful Use requirements, and may make it difficult to access the information to conduct CPSP QA activities. Please see the document, "Overview of National and State Resources for Electronic Health Record Adoption" for information on Meaningful Use.

The following questions can assist providers to evaluate the functionality of CPSP EHRs. If a provider has already implemented an EHR system, these questions can be useful for planning system upgrades.

1. Does the EHR document CPSP client orientation, initial assessments, 2nd and 3rd trimester reassessments, postpartum assessments, and Individualized Care Plans (ICPs) in all four domains (obstetric, psychosocial, nutrition, and health education) as required by Title 22?
2. Does the EHR generate reports that will enable the provider and County PSC to conduct QA to monitor delivery of services and outcomes?
3. Does the system recognize risk conditions from the assessments, reassessments, and postpartum assessments?
4. Will the system automatically populate the ICP with information from the assessment results/risks/problems and link to appropriate:
    - Site specific CPSP protocols
    - CPSP Steps To Take (STT) Guidelines
    - STT Patient handouts
    - Resources/Referrals
5. Will the system automatically populate applicable lab results in the CPSP assessments as well as other appropriate locations in the EHR?
6. When the height and weight are entered into the system, will the system automatically select and plot the correct weight gain grid?
7. Is the system user friendly to enable the provider to easily review previous assessment results, and the ICP before conducting a reassessment or postpartum assessment?
8. Does the system recognize CPSP services to enable correct billing and can it easily implement coding changes?