Healthy Beginnings Plus
Care Coordination Record

EDC_____

SECTION I - GENERAL INFORMATION

1. Name - Recipient (Last, First, Middle Initial)

2. Date of Birth - Recipient

3. Age - Recipient

4. Ethnicity ☐ Hispanic ☐ Non-Hispanic

5. Race ☐ American Indian ☐ Asian ☐ African American ☐ Hawaiian / Pacific Islander ☐ Caucasian ☐ Other

6. Education (Indicate highest grade completed)
☐ Primary / Secondary (1-12) _____ ☐ College (1-4 or 5+) _____

7. Marital Status
☐ Single ☐ Married

8. Address - Recipient (Street, City, State, Zip Code) County
Street:_____
City:_____ State:_____ZIP:_____

9. Is the father of the baby involved?
☐ Yes ☐ No
Name:_____ Age:____

10. Telephone Number - Recipient
Home: (____) _____ Work: (____) _____
Cell: (____) _____

11. Other Telephone Number - Recipient
(____) _____

12. What is the best way to contact you?
☐ Home ☐ Work ☐ Cell
What is the best time to contact you?
☐ Day ☐ Evening

13. Name and Telephone Number - Emergency Contact Person
1. _____
2. _____

14. Name - Medical Provider or Clinic (Doctor, Nurse, Practitioner, Midwife)
Name: _____
Address: _____
Phone: _____

15. Recipient Medicaid Identification Number
_____

16. Primary Language
A. READING English____ Other_____
B. SPEAKING English____ Other_____

17. When was your last dental exam? Who is your dentist?

SECTION II - CURRENT PREGNANCY

1. What date did you first suspect you were pregnant?

2. What was the first day of your last menstrual cycle?
LMP:_____EDC:_____

3. Is this a planned pregnancy?
☐ Yes ☐ No

4. Have you been seen anywhere else for prenatal care?
☐ I have not seen anyone yet
☐ I have an appointment set for (mm/dd/yy)_____

5. Your Weight Before Pregnancy _____
Your Current Weight _____
Your Height _____

6. Are you planning to breastfeed your baby?
☐ Yes ☐ No

7. Have you had a Human Immunodeficiency Virus (HIV) test during the past year?
☐ Yes ☐ No

8. Have you had any bleeding or cramping?
☐ Yes ☐ No

9. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)?
☐ Yes ☐ No

SECTION III - PREGNANCY HISTORY (If this is a first pregnancy, skip to Section IV.)

1. How many times have you been pregnant before? G_____ P_____	2. Number of full-term babies?	3. Number of babies born more than 3 weeks early.
4. Number of miscarriages. _____	5. Number of IUFDS? _____	6. Number of living children.
7. Number of babies weighing less than 5 1/2 pounds at birth.	8. What hospital did you deliver at? Name:_____ Addressss:_____	9. Have you been pregnant in the last year?

10. Outcome of last pregnancy. ☐ Live birth ☐ Miscarriage / Other loss

SECTION IV - CONCERNS

1. How many times a day do you floss_____, brush_____.

2. Before pregnancy, did you smoke cigarettes? If Yes, indicate the average number of cigarettes smoked per day. _____	☐ Yes ☐ No
3. Since you have been pregnant, have you smoked cigarettes? If Yes, indicate the average number of cigarettes smoked per day. _____	☐ Yes ☐ No
4. Does anyone in your household smoke?	☐ Yes ☐ No
5. In the three months before your current pregnancy, did you use any form of alcohol? If Yes, indicate the average number of drinks consumed per week. _____	☐ Yes ☐ No
6. Since you have been pregnant, have your used alcohol? If Yes, indicate the average number of drinks consumed per week. _____	☐ Yes ☐ No
7. In the past year, have you used street, prescription or OTC drugs? If Yes, indicate which drugs. _____	☐ Yes ☐ No
8. Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you?	☐ Yes ☐ No
9. Do you feel safe where you live?	☐ Yes ☐ No
10. During the past month, did you miss any meals, not eat when you were hungry, or use a food bank because there was not enough food or money to buy food?	☐ Yes ☐ No
11. Have you had any housing problems in the past three months?	☐ Yes ☐ No
12. Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments?	☐ Yes ☐ No
13. Have you had problems with depression or received counseling or medications for mental health concerns?	☐ Yes ☐ No
14. During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless?	☐ Yes ☐ No
15. How do you rate your current stress level?	☐ High ☐ Medium ☐ Low
16. How many people can you count on when you need help?	☐ 0 ☐ 1-2 ☐ 3+

Name_____ RID_____ EDC_____

SECTION IV - CONCERNS (continued)

17. Which of these things worry you a lot? Check all that apply.

- ☐ Money problems
- ☐ My job
- ☐ My partner's job or unemployment
- ☐ My partner's drinking or drug use
- ☐ My own drinking or drug use
- ☐ My partner is in jail
- ☐ My relationship with my partner
- ☐ My partner did not want this pregnancy
- ☐ Labor and delivery
- ☐ Caring for this baby
- ☐ Caring for my other children
- ☐ Other

18. What worries you the most?

19. What do you do to deal with your problems?

20. Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?

21. Please check the box of any of these services being utilized by the recipient:

- ☐ Nutritional Counseling
- ☐ Smoking Cessation
- ☐ Childbirth Classes
- ☐ Parenting Classes
- ☐ Breastfeeding classes through WIC
- ☐ D & A Counseling
- ☐ MATP

Signature - Staff Completing Assessment | Date Signed

Signature - Qualified Health Professional (If different from above) | Date Signed

Name_____ RID_____ EDC_____

Healthy Beginnings Plus
Care Coordinator Health Promotion Log

MA #: _____ EDC: _____

Medical Record #: _____

Patient's Name: _____

FIRST TRIMESTER
(0 - 14 Weeks of Gestation)

TOPIC DISCUSSED	DATE	NEEDS FOLLOW UP	COMMENTS	INITIALS
HEALTHY BEHAVIORS • Nutrition, including - basic four food groups - need for increased calories and nutritional intake • Dental care • Avoidance of: - drugs including illicit, over the counter (OTC), prescription (Rx) - alcohol - tobacco - radiation/chemical exposure at home/work place • Safer sex - STDs • Relaxation and exercise • Maternal seatbelt use				
GENERAL KNOWLEDGE ABOUT PREGNANCY • Developmental tasks for expectant mother, father and couple • Determination of gestational age - Calculation of EDC - Sequential comparison of uterine size - Division of pregnancy into trimesters • Embryonic/fetal G & D • Physiologic changes of pregnancy, including: - breast changes - nausea and vomiting - urinary frequency - fatigue • Psychological changes of pregnancy - changing self image - sexual adjustment				
INFORMATION ON PROPOSED CARE • Initial and on-going antenatal care - risk assessment • Initial prenatal labs as per ACOG Guidelines • Danger signs - bleeding - cramping • Lodging complaints • Travel • Expectation for care/care giver • Topics initiated by client/significant other				

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SECOND TRIMESTER
(15 - 28 Weeks of Gestation)

TOPIC DISCUSSED	DATE	NEEDS FOLLOW UP	COMMENTS	INITIALS
HEALTHY BEHAVIORS • Nutrition review, including - basic four food groups - need for increased calories and nutritional intake • Personal Hygiene - bathing - clothing • Avoidance of: - drugs including illicit, OTC and Rx - alcohol - tobacco - radiation/chemical exposure at home/work place • Safer sex - STDs • Relaxation and exercise • Body mechanics • Maternal seatbelt use				
GENERAL KNOWLEDGE ABOUT PREGNANCY • Developmental tasks for expectant mother, father and couple • Fetal growth and development - size and position - activity and movement - heart beat - size/gestational age relationship • Physiologic changes of pregnancy, - enlargement of abdomen - skin pigmentation - stria - vascular spiders • Psychological changes of pregnancy - fantasies and dreams - body image • Self-help for discomforts - backaches - constipation - round ligament pain - variosities - leg cramps - ankle edema				
INFORMATION ON PROPOSED CARE • On-going antenatal care risk assessment • Prenatal screening procedure - MSAFP • Breastfeeding benefits • Danger signs - bleeding - cramping - severe and prolonged vomiting • Plans for childbirth education classes • Expectation for care/care giver • Topics initiated by client/significant other				

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Care Coordinator Health Promotion Log

MA #: _____ EDC: _____

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Patient's Name: _____

THIRD TRIMESTER
(29 - 42 Weeks of Gestation)

TOPIC DISCUSSED	DATE	NEEDS FOLLOW UP	COMMENTS	INITIALS
HEALTHY BEHAVIORS • Nutrition review, including - basic four food groups - need for increased calories and nutritional intake • Avoidance of: - drugs including illicit, OTC and Rx - alcohol - tobacco - radiation/chemical exposure at home/work place • Safer sex - STDs • Relaxation and exercise • Body mechanics • Maternal seatbelt use				
GENERAL KNOWLEDGE ABOUT PREGNANCY • Developmental tasks for expectant mother, father and couple • Fetal growth and development - size and position - activity - size/gestational age relationship • Physiologic changes of pregnancy, - dyspnea - leg and feet cramps - constipation - indigestion - pedal edema - fatigue - vaginal discharge - urinary frequency • Psychological changes of pregnancy including: - anxiety about labor and birth - increased introspection • Self-help for discomforts including: - constipation - dyspnea - fatigue - indigestion				
INFORMATION ON PROPOSED CARE • On-going antenatal care - risk assessment • Travel • Danger signs - visual disturbances - headaches - hands and facial edema - vaginal bleeding - abdominal pain - PROM • Tests for fetal growth and well-being, including: - ultrasound - amniocentesis • Signs of approaching labor • Discomforts and pain during childbirth				

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Care Coordinator Health Promotion Log

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POSTPARTUM
(Birth to 3 Months)

TOPIC DISCUSSED	DATE	NEEDS FOLLOW UP	COMMENTS	INITIALS
HEALTHY BEHAVIORS • Nutrition - need for iron - breastfeeding mothers need increased nutrients and fluids • Avoidance of: - drugs including illicit, OTC, Rx and environmental toxins for breast feeding mothers • Maternal seat belt use				
GENERAL KNOWLEDGE OF POSTPARTUM PERIOD • Developmental tasks for new mother, new father and new family • Physiologic changes - involution - diaphoresis - weight loss - breast - scalp hair loss - discomforts • Psychological changes including: - depression - reality shock • Family planning services				
INFORMATION ON PROPOSED CARE • Episiotomy care • Postpartum follow-up visit • Coping Measures - relaxation and rest - exercise • Infant care and feeding, including: - infant temperament and communication - infant car seat use - umbilical cord care - bathing - 2-4 week follow-up visit - immunizations • Topics initiated by client/significant other				

Healthy Beginnings Plus
Comprehensive Problem List*

MA #: _____ EDC: _____

Medical Record #: _____

Patient's Name: _____

*To be used by all maternity care staff members.

#	PROBLEM	ACTION TAKEN	DATE ENTERED	ENTERED BY	DATE RESOLVED

Healthy Beginnings Plus
Comprehensive Problem List*

MA #: _____ EDC: _____

Medical Record #: _____

Patient's Name: _____

*To be used by all maternity care staff members.

#	PROBLEM	ACTION TAKEN	DATE ENTERED	ENTERED BY	DATE RESOLVED

Healthy Beginnings Plus
Comprehensive Problem List*

MA #: _____ EDC: _____

Medical Record #: _____

Patient's Name: _____

*To be used by all maternity care staff members.

#	PROBLEM	ACTION TAKEN	DATE ENTERED	ENTERED BY	DATE RESOLVED