STATE OF NEW JERSEY
PERINATAL RISK ASSESSMENT
Follow-up Form

ALL FIELDS REQUIRED **PLEASE PRINT CLEARLY**

Date Form Completed (MM-DD-YY) | Medicaid ID | Insurance ID | Insurance Effective Date (MM-DD-YY)

Provider Information

Chart # | Planned Delivery Site Code | NPI | Group

Patient Information

Last Name | First Name | Date of Birth (MM-DD-YY)

Street Address | City

Zip Code | County | Primary Phone - - | Preferred Contact ○ Text ○ Call

Emergency Contact Name | Emergency Contact Phone - -

Name of Father of the Baby

Father of Baby Involved ..... ○ Yes ○ No

Married .... ○ Yes ○ No

Race *(Choose one)*
○ Black
○ White
○ Asian

Ethnicity Hispanic ○ Yes
○ Native American
○ Multi-Racial
○ Alaskan/Pacific Islander
○ Other

Primary Language *(Choose one)*
○ English
○ Spanish
○ Other *(specify)* ______

Health Insurance *(Select all that apply)*
○ Medicaid PE
○ Medicaid FFS
○ Medicaid MCO
○ Medicare
○ NJ Family Care
○ Commercial/Private
○ Uninsured/Self Pay

Medicaid MCO *(Choose one)*
○ Aetna Better Health
○ Amerigroup
○ Horizon NJ Health
○ UnitedHealthcare Community
○ WellCare
○ None

Entry Into Prenatal Care

1st Visit (MM-DD-YY)

1st Visit Under MCO (MM-DD-YY)

LMP (MM-DD-YY)

EDD (MM-DD-YY)

Perinatal History

First pregnancy? ○ Yes ○ No *If Yes, skip to Physical Assessment*

Date of last live birth (MM-DD-YY) | Date of last other pregnancy outcome (MM-DD-YY)

______ # Pregnancies Including Current
______ # Previous Live Births
______ # Live Births Now Living
______ # Term Births ≥ 37 wks
______ # Preterm Births < 37 wks
______ # Previous Cesarean Sections
______ # Miscarriages < 20 wks
______ # Fetal Deaths ≥ 20 wks
______ # Induced Terminations
______ # Ectopic or Molar Pregnancies

Physical Assessment

Blood Pressure ___ / ___

Pre Pregnancy Weight (lbs) | Current Weight (lbs)

Height (ft-inches) -

Bleeding During Current Pregnancy
○ 1st Trimester ○ 3rd Trimester
○ 2nd Trimester ○ None

Infertility Treatment
If No Skip to Pregnancy Risk

○ No ○ Fertility enhancing drugs, artificial insemination or intrauterine insemination ○ Assisted reproductive technology (IVF, GIFT, ZIFT)

[ ] *Taken by Mother* [ ] *Taken by Father* [ ] *Insemination*

Pregnancy Risk Factors

Risk Factor	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Low Birth Weight (≤ 2500gm)	na	na	○	○	○
History of PROM	na	na	○	○	○
Hyperemesis	○	○	○	○	○
Obesity	○	○	○	na	na
Gestational Diabetes	○	○	○	○	○
Insulin Dependent	○	○	na	○	○
PIH/Preeclampsia	○	○	○	○	○
Eclampsia	○	○	○	○	○
Placenta Previa	○	○	○	○	○
Cervical Incompetence	○	○	○	○	○
Multiple Gestation	○	○	○	na	na

Risk Factor	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Fetal Reduction	○	○	○	na	na
Macrosomia	○	○	○	○	○
IUGR	○	○	○	○	○
Oligo/Polyhydramnios	○	○	○	○	○
Abnormal Amniocentesis	○	○	○	○	○
Abnormal AFP	○	○	○	○	○
Maternal Fetal Infection	○	○	○	○	○
Abdominal Surgery	○	○	○	na	na
Fetal Genetic/Structural Abnorm	○	○	○	○	○
Rh Negative	○	○	○	na	na
Pyelonephritis	○	○	○	○	○

Risk Factor	Current Pregnancy Y	N	Unk	Prior Pregnancy Y	N
Group B Strep	○	○	○	○	○
Urinary Tract Infection	○	○	○	na	na
Hepatitis A	○	○	○	na	na
Hepatitis B	○	○	○	○	○
Hepatitis C	○	○	○	○	○
Alcohol Use	○	○	○	○	○
Illicit Drug Use	○	○	○	○	○
Opiate Dependence	○	○	○	○	○
Opioid Replacement Tx	○	○	○	○	○
Cats or Birds in Home	○	○	○	na	na

Serial PRA ID

DO NOT PHOTOCOPY

DO NOT PHOTOCOPY BLANK FORMS DO NOT FAX FORMS

© 2017 Family Health Initiatives 2500 McClellan Ave, Ste 270 Pennsauken, NJ 08109
www.praspect.org

Draft

Provider Chart #

ALL FIELDS REQUIRED

Current Medical Conditions/Risks

	Yes	No	Unk	On Meds	Patient History		Yes	No	Unk	On Meds	Patient History		Yes	No	Unk	On Meds	Patient History
Neurological Condition	○	○	○	○	○	Blood Dyscrasia	○	○	○	○	○	Congenital Abnormalities	○	○	○	na	○
Seizures	○	○	○	○	○	Diabetes	○	○	○	○	○	Abnormal Pap Smear	○	○	○	na	na
Depression/Mental Illness	○	○	○	○	○	*Insulin Dependent*	○	○	na	na	na	STD	○	○	○	○	○
Asthma	○	○	○	○	○	Thyroid Disease	○	○	○	○	○	Allergies	○	○	○	○	○
Tuberculosis	○	○	○	○	○	Sickle Cell Trait	○	○	○	na	na	Sensitive/Bleeding Gums	○	○	○	○	na
Cystic Fibrosis	○	○	○	○	na	Sickle Cell Disease	○	○	○	○	na	2nd or 3rd Hand Smoke	○	○	○	na	na
Heart Condition	○	○	○	○	○	Liver Disease	○	○	○	○	○	Home Built Before 1978	○	○	○	na	na
Chronic Hypertension	○	○	○	○	○	Renal Disease	○	○	○	○	○	Dental Visit w/in the Year	○	○	○	na	na
Thalassemia	○	○	○	○	na	Lupus	○	○	○	○	na	HIV Positive	○	○	○	○	na
Phlebitis/DVT	○	○	○	○	○	Cancer	○	○	○	○	○	AIDS	○	○	○	○	na
Anemia	○	○	○	○	○	Uterine Abnormalities	○	○	○	na	na	HIV Test Refused	○	○	na	na	na

Psychosocial Risk Factors

	Yes	No	Unk		Yes	No	Unk		Yes	No	Unk
Disabled	○	○	○	Nutritional Concerns	○	○	○	Unemployed/Inadequate Income	○	○	○
Homeless	○	○	○	Unplanned Pregnancy	○	○	○	Husband/Partner is Unemployed	○	○	○
Unstable Housing	○	○	○	Perinatal Depression	○	○	○	Inadequate Social Support	○	○	○
Transportation	○	○	○	Domestic Violence	○	○	○	Currently in Foster Care	○	○	○
Eating Disorder	○	○	○	Education <12 Years	○	○	○				

Reason for Late Entry to Prenatal Care

	Yes		Yes
Transportation	○	Insurance Enrollment Delay	○
Financial	○	Couldn't Find a Health Provider	○
Child Care Issues	○	Unaware of Importance of PNC	○
Access to Preg Test	○	Abortion Desired/Unsuccessful	○
Unaware of Pregnancy	○		

Smoking/Tobacco Use

○ Non Smoker

How many cigarettes OR packs did you smoke per day in the three months before pregnancy? Cigarettes [ ][ ] OR Packs [ ]

4Ps Plus

	Yes	No
Did either of your parents have a problem with drugs or alcohol	○	○
Does your partner have any problem with drugs or alcohol	○	○
Have you ever felt manipulated by your partner	○	○
Have you ever felt out of control or helpless	○	○
Over the past 2 weeks		
Have you felt down, depressed or hopeless	○	○
Have you felt little interest or pleasure in doing things	○	○

	Yes	No
Have you ever drunk beer/wine/liquor	○	○

In the month before you knew you were pregnant	*Any	None
How many cigarettes did you smoke	○	○
How much beer/wine/liquor did you drink	○	○
How much marijuana did you use	○	○

If Any is checked, continue with the 4Ps Follow-Up Questions

4Ps Plus Follow-up Questions (if *Any above was checked)

In the month before you knew you were pregnant :	Refer for Assessment: Every Day	Refer for Assessment: 3-6 Days/Wk	Prevention Education: 1-2 Days/Wk	Prevention Education: <1 Day/Wk	No Referral Needed: Did Not Drink/Use Drugs
About how many days a week ***did you*** usually drink beer / wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○
And now, about how many days a week ***do you*** usually drink beer / wine / liquor	○	○	○	○	○
use any drug such as marijuana, cocaine or heroin	○	○	○	○	○

Referrals/Education

	Referred	Receiving Services	Referral Needed	Refused	Not Needed		Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation	○	○	○	○	○	Childbirth Education	○	○	○	○	○
Substance Abuse Prevention Ed	○	○	○	○	○	Breastfeeding Consult	○	○	○	○	○
Substance Abuse Assessment	○	○	○	○	○	Emergency Assistance	○	○	○	○	○
Mental Health Assessment	○	○	○	○	○	TANF/GA	○	○	○	○	○
Domestic Violence Assessment	○	○	○	○	○	WIC	○	○	○	○	○
Diabetes Care Program	○	○	○	○	○	SSI	○	○	○	○	○
Preterm Labor Prevention	○	○	○	○	○	DCP&P	○	○	○	○	○
Nutritional Consult	○	○	○	○	○	Food Stamps	○	○	○	○	○
Community Based Services*	○	na	na	○	○	Dental Referral	○	○	○	○	○

** Includes referrals to local Community Health Worker, Community Home Visiting and other supportive services*

Medications/Comments

____

____

____

____

____

Serial

PRA ID

DO NOT PHOTOCOPY BLANK FORMS

DO NOT FAX FORMS

© 2017 Family Health Initiatives 2500 McClellan Ave, Ste 270 Pennsauken, NJ 08109
www.praspect.org

DO NOT PHOTOCOPY