



# STATE OF NEW JERSEY PERINATAL RISK ASSESSMENT

## Third Trimester Form

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

42628

Date Form Completed

Medicaid ID

Insurance ID

Insurance Effective Date

MM - DD - YY

\_\_\_\_\_

\_\_\_\_\_

MM - DD - YY

### Provider Information

NPI

Group NPI

### Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Primary Phone \_\_\_\_\_  
County \_\_\_\_\_ Provider Chart # \_\_\_\_\_

### New Information

Name \_\_\_\_\_  
Address \_\_\_\_\_ County \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Preferred Contact  Call  Text

Prenatal Care  
Planned Delivery

Date of last prenatal care visit

Site Code

MM - DD - YY

# of prenatal care visits

MM - DD - YY

### Current Pregnancy Risk Factors

	Yes	No	Unk		Yes	No	Unk		Yes	No			
Toxoplasmosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CMV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperemesis	<input type="radio"/>	<input type="radio"/>	Maternal Fetal Infection	<input type="radio"/>	<input type="radio"/>
Listeria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HPV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Obesity	<input type="radio"/>	<input type="radio"/>	Abdominal Surgery	<input type="radio"/>	<input type="radio"/>
Influenza	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chlamydia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gestational Diabetes	<input type="radio"/>	<input type="radio"/>	Fetal Genetic/Structural Abnorm	<input type="radio"/>	<input type="radio"/>
Varicella Zoster	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<i>Insulin Dependent</i>	<input type="radio"/>	<input type="radio"/>	Pyelonephritis	<input type="radio"/>	<input type="radio"/>
Parvovirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PIH/Preeclampsia	<input type="radio"/>	<input type="radio"/>	Urinary Tract Infection	<input type="radio"/>	<input type="radio"/>
West Nile Virus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Group B Strep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eclampsia	<input type="radio"/>	<input type="radio"/>	Hepatitis A	<input type="radio"/>	<input type="radio"/>
Rubella	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Placenta Previa	<input type="radio"/>	<input type="radio"/>	Hepatitis B	<input type="radio"/>	<input type="radio"/>
Lyme Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rh Sensitization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cervical Incompetence	<input type="radio"/>	<input type="radio"/>	Hepatitis C	<input type="radio"/>	<input type="radio"/>
Malaria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					Multiple Gestation	<input type="radio"/>	<input type="radio"/>	Alcohol Use	<input type="radio"/>	<input type="radio"/>
								Macrosomia	<input type="radio"/>	<input type="radio"/>	Illicit Drug Use	<input type="radio"/>	<input type="radio"/>
								IUGR	<input type="radio"/>	<input type="radio"/>	Opiate Dependency	<input type="radio"/>	<input type="radio"/>
								Oligo/Polyhydramnios	<input type="radio"/>	<input type="radio"/>	Opioid Replacement Tx	<input type="radio"/>	<input type="radio"/>
								Abnormal Amniocentesis	<input type="radio"/>	<input type="radio"/>	Rh Negative	<input type="radio"/>	<input type="radio"/>
								Abnormal AFP	<input type="radio"/>	<input type="radio"/>			

### Current Medical Conditions/Risks

	Yes	No	Unk	On Meds		Yes	No	Unk	On Meds		Yes	No	Unk	On Meds					
Neurological Condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Phlebitis/DVT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	STD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Renal Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epilepsy/Seizure Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blood Dyscrasia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	na	AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression/Mental Illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Uterine Abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	na	Fever $\geq 100.4$ more than 24 hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sickle Cell Trait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	na	Abnormal Pap Smear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1st Trimester	<input type="radio"/>	<input type="radio"/>	None	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thalassemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2nd Trimester	<input type="radio"/>	<input type="radio"/>	Unknown	<input type="radio"/>
Heart Condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											3rd Trimester	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>

### Current Psychosocial Risk Factors

	Yes	No		Yes	No
Disabled	<input type="radio"/>	<input type="radio"/>	Perinatal Depression	<input type="radio"/>	<input type="radio"/>
Homeless	<input type="radio"/>	<input type="radio"/>	Domestic Violence	<input type="radio"/>	<input type="radio"/>
Unstable Housing	<input type="radio"/>	<input type="radio"/>	Education <12 Years	<input type="radio"/>	<input type="radio"/>
Transportation Problems	<input type="radio"/>	<input type="radio"/>	Unemployed/Inadequate Income	<input type="radio"/>	<input type="radio"/>
Eating Disorder	<input type="radio"/>	<input type="radio"/>	Husband/Partner Unemployed	<input type="radio"/>	<input type="radio"/>
Nutritional Concerns	<input type="radio"/>	<input type="radio"/>	Inadequate Social Support	<input type="radio"/>	<input type="radio"/>
			Currently in Foster Care	<input type="radio"/>	<input type="radio"/>

Child(ren) diagnosed with an Autism Spectrum Disorder?

Yes  No  
 Unknown  N/A

Family History of Congenital Anomalies or Syndromes

Yes  No  
 Unknown  N/A

Prenatal Vitamins

1st Trimester  None  
 2nd Trimester  Unknown  
 3rd Trimester

Blood Type

A  AB  Negative  
 B  O  Positive

### Prenatal Fetal Diagnoses *Select all that apply*

Coarctation of the Aorta  Double Outlet Right Ventricle  Tricuspid Atresia  Transp of Great Arteries  Interrupted Aortic Arch  Tetralogy of Fallot

Total Anomalous Pulmonary Venous Return  Ebstein Anomaly  Hypoplastic Left Heart  Truncus Arteriosus  Pulmonary Atresia  None of the above

Other Cardiac Anomaly  Other Non-Cardiac Anomaly  Single Ventricle  Unknown

*Specify* \_\_\_\_\_ *Specify* \_\_\_\_\_

PRA ID \_\_\_\_\_

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Patient Name

[Empty box for Patient Name]

ALL FIELDS REQUIRED

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**HIV** Was mother known HIV positive entering prenatal care? *If Yes, Skip to Prenatal Procedures*  Yes  No

Was mother counseled regarding the benefits of HIV testing during the pregnancy?  Yes  No

If Yes, when?  1st Trimester  2nd Trimester  3rd Trimester

If Yes, where?  Provider Office  Hospital Labor/Delivery

**1st Trimester HIV Specimen Information**

HIV testing obtained upon receipt of prenatal care?  Yes  No  Refused

Date Specimen Obtained: [MM] - [DD] - [YY]

Where?  Prenatal Provider  HIV Provider  Hospital Labor/Delivery  None  Other Specify \_\_\_\_\_

**3rd Trimester HIV Specimen Information**

HIV testing obtained during 3rd trimester of pregnancy?  Yes  No  Refused

Date Specimen Obtained: [MM] - [DD] - [YY]

Where?  Prenatal Provider  HIV Provider  Hospital Labor/Delivery  None  Other Specify \_\_\_\_\_

**Source of HIV Information**

Source of HIV related Information *Select all that apply*  Mother's Medical Records  Patient's Verbal History  Medical Provider Interview  None

Hepatitis B Serology Obtained?  Yes  No  Unknown

Date of HBSAg Test: [MM] - [DD] - [YY]

Syphilis Serology Obtained?  Yes  No  Unknown

Hepatitis B Surface Antigen Positive? (HBSAg)  Yes  No  Unknown

If Yes, Date Syphilis Serology Obtained? [MM] - [DD] - [YY]

**Prenatal Procedures** *Select all that apply*

Tocolysis  Cervical Cerclage  External Cephalic Version Attempted

CVS  Amnio Genetic Screening  Successful  Failed

Selective Fetal Reduction  Amnio Assess Lung Maturity

Cell Free DNA Test  Amnio Other Purpose  None of these procedures performed

Fetal Ultrasound Performed If Yes, When?  1st Trimester  2nd Trimester  3rd Trimester

Yes  No  Number of Ultrasounds: [ ]

**Smoking/Tobacco Use**

Non Smoker *If Non Smoker skip to 4Ps Plus*

How many cigarettes OR packs did you smoke per day during each of the following time periods? *If none during any time period enter zero (0)*

1st Trimester: Cigarettes [ ] Packs [ ] OR

2nd Trimester: Cigarettes [ ] Packs [ ] OR

3rd Trimester: Cigarettes [ ] Packs [ ] OR

**4Ps Plus**

	Yes	No		Yes	No
Did either of your parents have a problem with drugs or alcohol	<input type="radio"/>	<input type="radio"/>	Have you ever drunk beer/wine/liquor	<input type="radio"/>	<input type="radio"/>
Does your partner have any problem with drugs or alcohol	<input type="radio"/>	<input type="radio"/>	In the month before you knew you were pregnant	<b>*Any</b>	<b>None</b>
Have you ever felt manipulated by your partner	<input type="radio"/>	<input type="radio"/>	How many cigarettes did you smoke	<input type="radio"/>	<input type="radio"/>
Have you ever felt out of control or helpless	<input type="radio"/>	<input type="radio"/>	How much beer/wine/liquor did you drink	<input type="radio"/>	<input type="radio"/>
Over the past 2 weeks			How much marijuana did you use	<input type="radio"/>	<input type="radio"/>
Have you felt down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>			
Have you felt little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>			

**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	3-6 Days/Wk	Prevention Education 1-2 Days/Wk	<1 Day/Wk	No Referral Needed Did Not Drink/Use Drugs
About how many days a week <i>did you</i> usually drink beer/wine/liquor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
use any drug such as marijuana, cocaine or heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
And now, about how many days a week <i>do you</i> usually drink beer/wine/liquor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
use any drug such as marijuana, cocaine or heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

PRA ID [ ]

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