Oklahoma HealthCare Authority

# OKLAHOMA HEALTH CARE AUTHORITY
# PRENATAL PSYCHOSOCIAL ASSESSMENT FORM

## INFORMATION ABOUT YOU

**To Be Completed By Patient**

**This information will be used to assist your health care provider in providing you with quality health care services. Your information will be kept confidential.**

**Circle "Y" for Yes or "N" for No or check box.**

**NAME**_____
**(PLEASE PRINT)** **LAST NAME / FIRST NAME / MIDDLE INITIAL**

**Date of Service:** _____

### WORK/ SCHOOL

| | | |
|---|---|---|
| Y | N | Are you employed? |
| Y | N | Have you experienced the loss of a co-worker and/or friend at work or school? |
| Y | N | Have you been threatened recently at work or school? |
| Y | N | Have you been involved in an argument or fight at work or school? |
| Y | N | Have you recently changed jobs? |
| | | Have you recently<br>☐ Changed school<br>☐ Quit School |

### ACTIVITIES

| | | |
|---|---|---|
| Y | N | Do you use heavy equipment? |
| Y | N | Do you work long hours? |
| Y | N | Do you do heavy housework? |
| Y | N | Do you often stand for 30 minutes or more at a time? |
| Y | N | Do you often lift more than 20 pounds? |
| Y | N | Do you have problems climbing stairs? |
| Y | N | Do you play sports? |
| Y | N | Do you ride in a car more than one (1) hour a day? |
| Y | N | Do you have a disability that limits activity? |

### EXPOSURE

| | | |
|---|---|---|
| | | Are you exposed to: |
| Y | N | Paint thinners or oven cleaners? |
| Y | N | Strong cleaners? |
| Y | N | Cat litter? |
| Y | N | Mercury or lead? |
| Y | N | Ceramics, stained glass, or jewelry making products? |
| Y | N | Have you eaten raw or uncooked meat? |
| Y | N | Do you smoke? |
| Y | N | Do others smoke around you? |
| Y | N | Do you wear your seat belt? |
| | | How many sexual partners have you had in the past year? _____ |

### HOUSEHOLD

| | | |
|---|---|---|
| Y | N | Do you have children?<br>Ages: _____ |
| Y | N | Do you care for a family member with a disability? |
| Y | N | Do you have a serious illness? |
| Y | N | Recent or planned move? |
| Y | N | Do you feel sleepy or tired a lot? |
| Y | N | Do you feel safe where you live? |
| Y | N | Do you or anyone in your house ever go to bed hungry? |

### SOCIAL SUPPORT

| | | |
|---|---|---|
| Y | N | Do you have any problems that keep you from health care appointments? |
| Y | N | Do you have family who will help you? |
| Y | N | Do you have friends you can count on when you need help? |
| Y | N | Are you not getting along with or arguing with your:<br>☐ Partner<br>☐ Parent<br>☐ Friends<br>☐ Child<br>☐ Other _____ |

### RESOURCES

| | | |
|---|---|---|
| Y | N | Do you have a car or access to transportation? |
| Y | N | Do you have access to a telephone? |
| | | Do you receive:<br>☐ Food Stamps<br>☐ TANF/Welfare<br>☐ Help with Child<br>☐ Care Help with<br>☐ Housing WIC |

### INFORMATION ON BABY'S FATHER

| | | |
|---|---|---|
| Y | N | Do you know for certain whom the father of the baby is?<br>If yes, what is the age of the baby's father? _____ |
| Y | N | Is the baby's father here with you today?<br>How long have you known the baby's father? _____ |
| Y | N | Is the baby's father happy about your pregnancy? |
| Y | N | Do you currently live with the baby's father? |

| | | |
|---|---|---|
| Y | N | Are you married to the baby's father? |
| Y | N | Is the baby's father currently married to someone else? |
| Y | N | Does the baby's father have children not in the home?<br>If yes, how many children does he have? _____ |

### IF YOUR CURRENT PARTNER IS NOT THE BABY'S FATHER

| | | |
|---|---|---|
| | | What is his/her age?_____<br>How long have you known your partner? _____ |
| Y | N | Is he/she happy about your pregnancy? |
| Y | N | Does you partner have children not in the home?<br>If yes, how many does he/she have? ____ |

Patient Signature: Date:

This information has been reviewed and discussed with the patient.

Health Care Provider Signature and Title: Date:

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**PRENATAL PSYCHOSOCIAL ASSESSMENT FORM**

## INFORMATION ABOUT PATIENT

## To Be Completed By the Health Care Provider with the Patient

**Patient Name:** | **Date of Service:**

### LIFE STRESSORS

| | | |
|---|---|---|
| Y | N | Was your pregnancy planned? |
| Y | N | Do you want to parent this child? |
| Y | N | Do you have enough money to pay for food, housing & bills? |
| Y | N | Have you recently experienced an extremely stressful event (house fire, tornado, death)? |

### MENTAL HEALTH

| | | |
|---|---|---|
| Y | N | Do you feel overwhelmed, sad, hopeless, or lost pleasure in the things you usually enjoy? |
| Y | N | Are you having any problems sleeping? |
| Y | N | Have you recently thought about suicide? |
| Y | N | Have you ever attempted suicide? When _____ |
| Y | N | Have you ever been diagnosed with a mental health condition? |
| Y | N | Have you been hospitalized for a mental health condition? |
| Y | N | Did you attend or currently attend mental health counseling? |

### VIOLENCE / ABUSE

| | | |
|---|---|---|
| Y | N | Are you ever afraid of your partner? |
| Y | N | In the last year, has anyone at home hit, kicked, punched or otherwise hurt you? |
| Y | N | In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do? |
| Y | N | In the last year, has anyone at home threatened to hurt you? |
| | | Have you in the past or recently been a victim of: |
| Y | N | Rape/Sexual Assault? ☐ Past ☐ Recent |
| Y | N | Mental Abuse? ☐ Past ☐ Recent |
| Y | N | Crime Victim? ☐ Past ☐ Recent |
| Y | N | Have you ever been investigated for hurting or neglecting a child? |

### BABY'S FATHER OR CURRENT PARTNER IN THE HOME

| | | |
|---|---|---|
| | | Does you baby's father or your current partner use |
| Y | N | Tobacco? |
| Y | N | Alcohol? |
| Y | N | Marijuana? |
| Y | N | Cocaine? |
| Y | N | IV Drugs? |
| Y | N | Meth? |
| Y | N | Is he bi-sexual? |
| Y | N | Does he have multiple partners? |
| Y | N | Is the baby's father or your current partner employed? |

### NUTRITION

| | | |
|---|---|---|
| | | What do you consider to be your healthy weight? _____ |
| Y | N | Do you eat at least 3 meals a day? |
| Y | N | Are you on a special diet? |
| Y | N | Do you take folic acid? |
| Y | N | Do you have current or past problem with an eating disorder? |
| Y | N | Do you have any dental problems? |
| | | When was your last check up? _____ |

### LIMITATIONS

| | | |
|---|---|---|
| Y | N | Do you have any vision problems? |
| Y | N | Can you hear without problems? |
| Y | N | Do you have any speech problems? |
| Y | N | Do you have any learning problems? |
| Y | N | Do you have any physical limitations? |

### FEARS / ANXIETIES ABOUT PREGNANCY AND PARENTING

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Personal Health Personal | Y | N | Hospital | Y | N | Labor/Delivery |
| Y | N | Safety | Y | N | Surgery | Y | N | Infant Illness Infant |
| Y | N | Fetal Condition | Y | N | Anesthesia | Y | N | Attachment |
| Y | N | Early Pregnancy Loss | Y | N | Perinatal Loss | Y | N | Parenting Skills |
| Y | N | Pregnancy Complications | | | | | | |

**REFERRALS:**

**ADDITIONAL COMMENTS:**

Health Care Provider Signature and Title: | Date:

# PROVIDER INSTRUCTIONS

## Purpose

Early assessment of maternal psychosocial stress and subsequent psychosocial intervention is essential to reduce adverse outcomes for both the mother and infant. The *Prenatal Psychosocial Assessment* is designed to provide a comprehensive, standardized format for the assessment and documentation of psychosocial issues in the pregnant patient and referral to resources or services.

## Use

The *Prenatal Psychosocial Assessment* in conjunction with an American College of Obstetricians and Gynecologist (ACOG) assessment or form covering the same elements as ACOG "collectively referred to as the Prenatal Risk Assessment" should be conducted as early as possible in the pregnancy, preferably at the first visit. The patient should be reassured that the information obtained during the assessment process is important to her care and will remain confidential. The Prenatal Risk Assessment must be appropriately completed and included in the prenatal record. A member can receive a maximum of 2 assessments per pregnancy; 1 assessment per provider allowed. **Page one is designed for completion by the patient** with review by the practitioner. The patient should be assessed for ability to read and/or need for assistance in completing the document. If possible, the patient should complete in private and alone. **Page two is to be completed by the physician** (OB/GYN, MFM, family practitioner, and general practitioner), advanced registered nurse, or PA, or appropriate medical staff, with the patient. Page two is not designed for patient self-use.

## Guidance for Provider Review or Patient's Response to Page One

- **WORK/SCHOOL:** Assess employment and/or school activities, recent changes and relationships. Sudden or frequent changes should be discussed to assess level of stress, anxiety or unresolved issues.

- **ACTIVITIES:** Assess level of activity that could have an impact during pregnancy depending on particular stress.

- **EXPOSURE:** Assess environmental risk to toxins and behaviors that increase risk to mother and fetus.

- **HOUSEHOLD:** Assess level of stress and safety in the household. If caring for a family member with a disability or special health care need, inform of possible eligibility for respite services and refer to Oklahoma Respite Resource Network at 1-800-426-2747 or http://oasis.ouhsc.edu/index.htm.

- **SOCIAL SUPPORT:** Assess support systems for the mother. If the mother indicates she has no supports, explore relationships with family and friends. Explore other social activities, neighbors or church where social supports could be developed.

- **RESOURCES:** Assess financial resources and ability to keep future appointments. Refer to local Oklahoma Department of Human Services for applications for financial and other assistance located at http://www.okdhs.org/okdhslocal/. Individuals eligible for SoonerCare (Medicaid) can receive transportation assistance to appointments by calling Sooner Ride at 1-877-404-4500 or 1-800-722-0353 TDD 8 a.m. to 6 p.m. Monday through Friday or 8 a.m. to 1 p.m. Saturday.

- **INFORMATION ON BABY'S FATHER OR OTHER PARTNER:** Assess the support of the baby's father or patient's partner in the life of the mother and this pregnancy.

## Guidance for Provider Completion of Page Two

### Interview:

In each section, record patient response to questions by circling "Y" for yes or "N" for no and/or checking appropriate box. The interviewer should maintain a supportive manner and tactful approach in questioning the patient. When possible the interviewer should be someone who has already developed a rapport with the patient because of the personal nature of the questions.

- **LIFE STRESSORS:** Assess if this pregnancy was planned, unplanned or undesired and other stress factors. If the pregnancy is unplanned, discuss her feelings and the father's feelings about the pregnancy at this time. If the pregnancy is undesired refer to local resources for counseling.

- **MENTAL HEALTH:** Assess for history of depression, current depression and/or suicidal tendencies or ability to cope. Contact Oklahoma Department of Mental Health and Substance Abuse Services, Reachout Hotline at 1-800-522-9054 for mental health and substance abuse services. Contact Heartline Suicide Hotline at 1-800-784-2433 for consultation or assistance if needed.

- **VIOLENCE/ABUSE:** Assess for history of abuse or intimate partner violence in the past or current. If positive for current intimate partner violence, assess for severity and whether individual has a safety plan. Contact Oklahoma SAFELINE at 1-800-522-SAFE (7233) for consultation or assistance if needed. This same number can be provided to individuals as a resource. If abuse was in the past, did the individual attend counseling to address?If not, how has she coped with the abuse and would she like to be referred to counseling to address?
- **BABY'S FATHER OR CURRENT PARTNER IN THE HOME:** Assess high-risk behaviors that may indicate need for additional assessment.

- **NUTRITION:** Assess eating habits, level of understanding of nutrition and dental care. Nutrition education is available to eligible participants through the Woman, Infants and Children (WIC) Program. For additional information call 1-888-655-2942 or locate a local WIC Site at www.health.state.ok.us/program/wic/sites.html. To locate a registered dietetic counselor or technician refer to www.oknutrition.org (Oklahoma Dietetic Association). Information on the Perinatal Dental Access Program, available for women who are pregnant or have recently delivered and are enrolled in SoonerCare, can be found at http://www.okhca.org/providers.aspx?id=3095.
- **LIMITATIONS:** Assess any limitations or disabilities that may indicate need for additional assessment.

- **FEAR/ANXIETY ABOUT PREGNANCY AND PARENTING:** Explore reasons for any fears and anxieties and provide information to reduce or alleviate fears or anxieties.

### Referrals:

All referrals should be listed. If further documentation is needed regarding referrals, write, "See Progress Notes" and enter this information in the progress notes.

### Additional Comments:

Any explanation or additional information is recorded in this section. If additional space is required, document the additional information in the progress notes, and write "See Progress Notes" in space provided.

### Signature, date and initials:

All staff providing services to the patient should sign, provide title, indicate date service was provided and initial at bottom of the form. If more than one provider is providing service, each staff member should initial the section they complete.