11931

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Perinatal Screening, Risk Assessment and Referral Form

Note: Instructions on back of form.

Please Print Clearly

Date Form Completed: MM - DD - YY

Insurance ID

Patient Information

Last Name | First Name | Date of Birth: MM - DD - YY

Street Address | City | ZIP

State | Home Phone | Wrk/Cell Phone | Emergency Phone

Race Ethnicity (choose one)
- O African American
- O Hispanic
- O Caucasian
- O Asian
- O American Indian
- O Multi-Racial
- O Other

Primary Language (choose one)
- O English
- O Spanish
- O Other

Entry Into Prenatal Care
- Gravida
- Para: T P AB L
- EDC: MM - DD - YY
- LMP: MM - DD - YY

Health Insurance (choose one)
- O Medicaid PE
- O Medicaid FFS
- O Medicaid MC
- O NJ Family Care
- O Commercial
- O Uninsured/Self Pay

HMO (choose one for Medicaid Eligibles)
- O None
- O Horizon NJ Health
- O University Health Plans
- O AMERIGROUP
- O AmeriChoice
- O Health Net

Date of First Visit: MM - DD - YY

Blood Pressure: /

Weight (lbs) | Height (Ft-Inches)

Pregnancy Risk Factors	Prior Pregnancy Y	Prior Pregnancy N	Current Pregnancy Y	Current Pregnancy N
Pre-term Labor	O	O	O	O
Cervical Incompetence	O	O	O	O
Gestational Diabetes	O	O	O	O
PIH/Preeclampsia	O	O	O	O
Low Birth Weight (<2500 gm)	O	O	na	na
Fetal Death	O	O	na	na
Multiple Gestation	na	na	O	O
Birth Defect	O	O	O	O
Depression	O	O	O	O
Genetic Counseling	O	O	O	O

Social Risk Factors	Yes	No
Disabled	O	O
Unemployed	O	O
Husband/Partner is Unemployed	O	O
Unmarried	O	O
Homeless	O	O
Unstable Housing	O	O
History Mental Health Treatment	O	O
Transportation Problems	O	O
Education < 12 years	O	O
Currently in Foster Care	O	O

Medical Conditions	Yes	No	OnMeds
High Blood Pressure	O	O	O
Kidney Disease	O	O	O
Diabetes	O	O	O
Asthma	O	O	O
Heart Condition	O	O	O
HIV Pos	O	O	O
AIDS	O	O	O
STD	O	O	O
Thyroid Disease	O	O	O
Seizures	O	O	O
Other	O	O	O

Oral Health Observations and Referral	Yes	No
Swollen/Bleeding Gums	O	O
Observed:	O	O
Broken/Decayed Teeth	O	O
Observed:	O	O
Loose Teeth	O	O
Reported:	O	O
Observed:	O	O
Dental Referral Given	O	O
Patient Education Given	O	O

4Ps Plus

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

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

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

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

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

In the month before you knew you were pregnant :

	Refer for Assessment: Every Day	Refer for Assessment: 3-4 Days/wk	Prevention Education: 1-2 days	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	O	O	O	O	O
use any drug such as marijuana, cocaine or heroin	O	O	O	O	O
And now, about how many days a week do you usually drink beer / wine / liquor	O	O	O	O	O
use any drug such as marijuana, cocaine or heroin	O	O	O	O	O

Behavioral Health Referrals / Social Service Involvement

	Yes	No	Refused
Substance Abuse Prevention Ed	O	O	O
Tobacco Cessation	O	O	O
Mental Health Assesssment	O	O	O
Domestic Violence Assessment	O	O	O
Substance Abuse Assessment	O	O	O
TANF	O	O	O
GA	O	O	O
SSI	O	O	O
Food Stamps	O	O	O
WIC	O	O	O
DYFS	O	O	na

Planned Delivery Site Code

NPI # / Provider #

Provider Information

Provider Chart #

Provider FAX (required)

Provider Phone

Screener Name

11931

Version-1: TF11931 BCAPS-20070726

Please complete and fax to: 856-662-4321

Instructions for Completing and Submitting the Universal Prenatal Risk Assessment Form

The Universal Prenatal Risk Assessment (PRA) form is to be completed by the treating obstetric service provider. Accurate completion of this form will expedite continuity of treatment and care for mother and baby.

General Instructions:

- **PRINT CLEARLY and INSIDE the boxes provided.**
- Fill circles completely for each answer
- **Additional text written on the form cannot be scanned and will not be transmitted**
- If information is 'not applicable', leave the space blank
- Fill in the OnMeds circle **only** when a patient is taking medication for a condition.

Select Only One Response for:

Race/Ethnicity
Primary Language
Health Insurance
HMO

Insurance ID: Put the HMO ID, Medicaid ID or Presumptive Eligibility ID in this section

Date of First Visit: All information in this section should reflect the patient's first visit status.

4 P's Plus Section: Complete the follow-up section if there is a positive response (Yes or Any) to **any** question. Identify whether a referral for assessment and/or prevention education was initiated.

Behavioral Health Referrals/Social Service Involvement: Choose one answer for each service listed: "Yes"= referral was given and accepted; "No"= referral was not indicated. "Refused" = referral was given and the patient refused

Provider Information: (This section must be complete in order to authorize services)

- Complete all fields including the area code
- DO NOT use a stamp to complete the information
- Use the Planned Delivery Site Code sheet provided to you to determine the code for each hospital
- The **fax number** for your practice is used to identify the site name and address which will be forwarded to the Plans.

Members of the Maternal and Child Health Consortia (MCH) of New Jersey and the NJ Prevention Network may be contacted for behavioral health referral assistance.

New Jersey Prevention Network, Inc.: (732) 367-0611
Regional Perinatal Consortium of Monmouth and Ocean Counties: (732) 363-5400
Northern New Jersey MCH Consortium: (201) 843-7400
Central New Jersey MCH Consortium: (732) 937-5437
Southern New Jersey Perinatal Cooperative: (856) 665-6000
Gateway/Northwest MCH Consortium: (973) 268-2280
Hudson Perinatal Consortium: (201) 876-8900

Abbreviations:

EDC – Estimated Date of Confinement
LMP – Last Menstrual Period
PE – Presumptive Eligibility
FFS – Fee for Service
MC – Managed Care
PIH – Pregnancy Induced Hypertension
SSI –Supplemental Security Income
TANF – Temporary Assistance for Needy Families
GA – General Assistance
WIC – Women Infants and Children (nutrition program)
DYFS – Department of Youth and Family Services
NPI – National Provider Identifier

WHEN FORM IS COMPLETED, FAX DAILY TO: 856-662-4321