



STATE OF NEW JERSEY PERINATAL RISK ASSESSMENT

First Visit Form

ALL FIELDS REQUIRED

PLEASE PRINT CLEARLY

Date Form Completed	Medicaid ID			Insurance ID			Ins	urance Effective D	ate			
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Provider Information							191	W D D				
Chart #		Planned Site Code	,									
Chart #	Group											
Patient Last Name				irst Name			Date of E	Sirth				
Information									. [
Street Address						City	M M	D D	YY			
								ΤŤΤΤ				
Zip Code Count			Primary Phone									
	,						Preferred Contact	O Text O	Call			
Emergency Contact Name						Emerge	ncy Contact Phone	O O				
Emergency contact Name	\Box				7	Emerger	Let Contact / Hone	_				
Name of Father of the Baby												
Name of Famer of the Baby	\Box	\Box					of Baby Involved		O No			
						Married		O Yes	O No			
Race Ethnicity Hispanic		ry Language	Health Insurance			Medica						
(Choose one) Native American	(Choose			Medicare NJ Family Ca	aro.	(Choose o	•	tedHealthcare Co	mmunity			
O White O Multi-Racial	O Sn			Commercial/F		O Aeti			IIIIIIuIIIty			
○ Asian○ Alaskan/Pacific○ Other	Islander Oth	ner <i>(specify)</i>		Uninsured/Se			zon NJ Health O No	ne				
Entry Into Prenatal Care		Perinatal His	tory First pregnancy? O Ye	os O No #	Von akin	to Dhysiaal	Agggerment Physical A	Assessment				
<u> </u>		<u>- 01111444111110</u>	rust pregnancy: O 1	25 0 100 11	res, skip	i iu Priysicai	, ioooooiiioiii					
		Data of last live	hirth	Data of last o	thar pro	ananev ou	Blood Pre	ssure				
1st Visit		Date of last live	e birth	Date of last o	ther pre	gnancy ou	tcome Blood Pre	ssure /				
M M D C		Date of last live	e birth	Date of last o	ther pre	_ - [rtcome Pre Pregn	ancy Current				
1st Visit	- _Y		e birth D D D V Y egnancies Including Current	Date of last o	D 1	- [Pre Pregn Weight (Ih	ancy Current				
M M D C	-	#Pr	D D Y Y	# M	liscarria (- [rtcome Pre Pregn Weight (lb	ancy Current Weight				
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ALL	FIEL	DS	REQ	UIREI
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Provider Chart #												

Current Medical Conditions/Risks On Patient On Patient On Patient On Patient										Patient									
	Yes	No	Unk		History			Yes	No	Unk		History			Yes	No	Unk		History
Neurological Condition	0	0	0	0	0	Blood Dyso	rasia	0	0	0	0	0	Congenita	al Abnormalitie	s O	0	0	na	0
Seizures	0	0	0	0	0	Diabetes		0	0	0	0	0	Abnormal	Pap Smear	0	0	0	na	na
Depression/Mental Illness	O	0	0	0	0	Insulin L	Dependent		0	na	na	na	STD		0	0	0	0	0
Asthma	Ŏ	Ŏ	Ŏ	Ŏ	Ŏ	Thyroid Dis	•	Ŏ	Ŏ	0	0	0	Allergies		Ŏ	Ŏ	Ŏ	Ŏ	Ŏ
Tuberculosis	Ö	Ö	Ö	Ö	Ö	Sickle Cell		Ö	Ŏ	Ŏ	na	na		Bleeding Gum		0	O	Ö	na
Cystic Fibrosis	Ö	Ö	Ö	Ö	na	Sickle Cell		Ö	Ö	Ö	0	na		Hand Smoke	0	Ö	0	na	na
Heart Condition	Ö	0	Ö	0	0	Liver Disea		Ö	0	Ö	0	0		ilt Before 1978	_	O	Ö	na	na
Chronic Hypertension						Renal Disea		_						sit w/in the Yea	_			na	na
	0	0	0	0	0		136	0	0	0	0	0			~	0	0		
Thalassemia	0	0	0	0	na	Lupus		0	0	0	0	na	HIV Posit	ive	O	0	0	0	na
Phlebitis/DVT	0	0	0	0	0	Cancer		0	0	0	0	0	AIDS	Deficed	0	0	0	0	na
Anemia	0	0	0	0	0	Uterine Abr	iormailues	0	0	0	na	na	HIV Test		0	0	na	na	na
Psychosocial Risk Fa	ICTORS Unk	<u>S</u>			Yes No	Unk				Yes	No U		ason for L	ate Entry to Yes	Prenat	al Car	<u>e</u>		Yes
			1.0			_								_	•	_		n 1	
Disabled O O	0		onal Cor		0 0			nadequate I					sportation	_	Insuran			,	0
Homeless O	0		nned Pre					ner is Unem		_		~	ncial		Couldn'				
Unstable Housing O	0		atal Depr stic Viole		0 0	_		icial Suppoi	π	0			d Care Issu	_	Unawar		•		_
Transportation O	0				00		ently in Fo	ister Care		0	0	~	ess to Preg	_	Abortior	ı Desire	eu/UIISC	iccessi	ui O
Eating Disorder O	0	Euuca	ntion <12	rears	00	0			_			Ulla	ware of Pre			D-	-1		
Smoking/Tobacco Us	<u>se</u>	Н	ow man	y cigai	rettes OR	packs did y	ou smoke	e per day i	in the t	three r	nonths	before	pregnancy	Cigare?	_	ов Г	cks T		
Non Smoker				, ,											'	JK _			
<u>4Ps Plus</u>						<u>Ye</u> :	s <u>No</u>							<u>Ye</u>	s <u>No</u>	<u> </u>			
Did either of your parent	s have	e a pro	blem w	ith dru	as or alco	ohol 🔘	0	Have	e vou e	ever di	runk be	eer/wine	/liauor	C) _			
Does your partner have					-	O	Q						1				If An	v is	
Have you ever felt mani				•	aloonoi	_	Ŏ	In th	o mon	th hofe	oro voi	ı know v	ou were pi	regnant *Aı	ny No	no.	chec	-	
,				IICI		O		lii ui	GILIOIT	iii beit	ore you	a Kilew y	ou were pi	egnant A	<u>iy ivo</u>	iiic	cont	inue v	vith
Have you ever felt out or	r contr	roi or n	ieipiess			C	0								_		the 4	lPs	
Over the past 2 weeks									How many cigarettes did you smoke										
Have you felt dov	vn, de	presse	ed or ho	peless		O	0	O How much beer/wine/liquor did you drink O O Questions											
Have you felt little	e inter	est or	pleasure	e in do	ing things		0		Но	w mu	ch mar	ijuana di	d you use	C) () [
4Ps Plus Follow-up C	uest	ions (if *Any	abov	e was d	hecked)					I.				1				
In the month be					,			efer for As			. !		ention Edu				erral N		
About how man							Eve	ery Day	3-6 Da	y5/VVK		1-2 Day	S/VVK <	l Day/Wk	Did	ו ואטנ ט	rink/Us	e Diug)S
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Referrals/Education	,	_	d Receivir		erral Refu						d Receiv				Medica	tions		onto	
Referrats/Education		Keleite	Service		eded Keit	Needed				Kelenec	Servic			Needed	vieuica	1110115/	COIIIII	ents	
Tobacco Cessation		0	0				Childb	irth Educat	ion	0	С			0					
Substance Abuse Prevention	n Ed		0				Breast	tfeeding Co	nsult	\circ	С			0					
Substance Abuse Assessme	ent	0	0				Emerg	gency Assis	tance	0	С			0					
Mental Health Assessment		\circ	0				TANF	/GA		\circ	С								
Domestic Violence Assessm	nent	0	0				WIC			0	С			0					
Diabetes Care Program		\circ	0		\circ) (SSI			0	С			0					
Preterm Labor Prevention		0	0		\circ		DCP&	P.		0	С) C		0					_
Nutritional Consult		0	0				Food S	Stamps		0	С			0					
Community Based Services	*	0	na	n	а С) (Denta	l Referral		0	С) C) (0					
* Includes referrals to local Con			Norker, Co	ommunit	ty														
Home Visiting and other suppor	uve ser	VILES																	

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