Clark County Health Department

517 Court St., Room 105 * Neillsville, WI 54456-1972 * (715)743-5105 * Toll Free 1-877-743-5105 * Fax (715)743-5115

http://www.co.clark.wi.us/

PNCC Chart Flowsheet/Checklist

RN-Care Coordinator: ______________________________

Client's Name: _____________________________________

Sphere ID #:_______________________________________

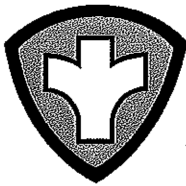
Yes	No	NA	
			Date of referral and source
			Client given RN's contact information; documented
			Client's Medical Assistance Number in Chart
			Client's SPHERE ID Number in Chart
			Date of first contact/appointment within 10 days of referral
			Eligible for PNCC services <18 years of age and/or score of 4 or more on pregnancy questionnaire
			Signed/dated Notice of Privacy Practices – client return receipt
			Signed/dated consent to release/obtain health care information
			Signed/dated consent for PNCC Medicaid billing
			Pregnancy questionnaire completed, signed/dated by PHN, and reviewed in face to face visit
			In person visit scheduled with client within 30 days or less after pregnancy questionnaire completed
			Sphere information data sheet filled out completely
			PNCC psychosocial assessment checklist completed once per trimester, and once postpartum –updates made to care plan if necessary 1st________ 2nd __________3rd_________ Postpartum_________
			Letter sent to client's physician, informing of client's enrollment in the PNCC program
			Verification of pregnancy from client's physician-physician signed/dated form
			Edinburgh postnatal depression scale (EPDS) completed by client once per trimester and once during the postpartum period (after 2 weeks postpartum) 1st_____________ 2nd _____________ 3rd______________ Postpartum ____________
			Care plan completed, signed/dated by client and nurse
			Documentation: client informed that care plan can be changed at anytime
			Initial care plan and updates entered in SPHERE; all updates signed or initialed and dated by PHN and client-at least every 60 days or sooner
			Client's collateral role (if applicable) identified in care plan
			Provide basic assessment/education on prenatal care, nutrition, postpartum, and infant care: utilize prenatal/postpartum health education topic checklist
			Client/collateral contacts every 30 days or sooner; if not document reason why
			All client/collateral contacts and attempted contacts documented. Progress notes dated, and signed by RN. Documentation includes: RN's name, description of reason of the contact, results of the contact, where the contact took place, and time of contact (ex. 2:00-3:30 pm)
			Referrals (written if possible) followed up on in within two weeks or less: utilize referral chart

			and client referral form-form must be completed and signed/dated by client
			Cribs for kids packet completed, including follow up questionnaire; if enrolled
Postpartum:			
			At least one face to face postpartum visit
			Infant assessment completed
			Postpartum assessment completed
			Postpartum care plan updated within 30 days of delivery
			PNCC evaluation survey given to client on last visit
			Date closed to PNCC(60 days postpartum)-discharged in PNCC enrollment screen in SPHERE
			After case closure, client's chart placed in MCH file cabinet
SPHERE Documentation Includes:			
			Client's demographic/household information
			Prenatal assessment
			Initial care plan and all updates; minimum updating every 60 days
			Health teaching
			Referrals
			Prenatal ongoing monitoring
			Postpartum assessment
			Infant assessment
Miscellaneous:			
			If PNCC services are terminated, client is notified, decision mutually agreed by RN and client, statement signed and dated by client indicating agreement with decision to terminate services. If not able to contact client, document all attempts.
			Document Code "743" if time is spent on physical assessments and their documentation-ex. taking infant's weight
			Client's who use tobacco are offered (enrolled if interested) in the First Breath Program
			Client's who use tobacco and/or exposed to secondhand smoke, are given information on the WI Tobacco Quit Line-(enrolled if interested)
			Client has condoms and emergency contraception on hand prior to delivery
			Client has chosen primary method of contraception and has a plan for continuation of those services.

Billing

Time log given to Program Assistant			Copy of time log in client's chart			Month
Yes	No	NA	Yes	No	NA	
						January
						February
						March
						April
						May
						June
						July
						August
						September
						October
						November
						December

Auditor's Signature:______________________________ Date: ________________



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NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Clark County Health Department is required to protect the privacy of personal health information and to give you this notice that describes our legal duties and privacy practices. In general, when we release your health information, we must release only the information needed to achieve the purpose of the use or disclosure. This Notice describes the types of uses and disclosures that we may make and gives you some examples. We are required to follow the procedures in this Notice. We reserve the right to change the privacy practices described and if we do so we will post the revised Notice, make copies available on request, and post the Notice on our website. We will follow all federal and state legal requirements in protecting your privacy. Contact the Clark County Health Department Director at 715-743-5105 for more information.

Permitted Use and Disclosure

We may use and disclose personal health information about you without your authorization in the following circumstances:

1. ***Provision of Health Treatment.***
   We may use and disclose information about you to provide, coordinate, and manage your health care and related services. For example, if we are providing care coordination of a pregnancy, we may use personal health information in your record to coordinate health treatment with your obstetrician.

2. ***Obtain Payment for Services***
   We may use and disclose information about you to bill and collect payment for treatment and services provided to you. For example, if we are providing you with a flu vaccine, we may use personal health information to bill your insurance as appropriate.

3. ***Health Care Operations***
   We may use your health information in order to improve the quality and efficiency of care we deliver. For example, we may use information about you as we review the skills and performance of health care providers in the health department, as we provide training for nursing students and other health professionals, as we cooperate with outside organizations that assess the quality of care we provide such as the State Department of Health and Family Services, and as we plan for future operations and services.

4. ***Other Circumstances***
   We may use and disclose personal health information under certain other circumstances without your authorization. These include:
   - When the use/disclosure in required by federal, state, or local law or other judicial/administrative proceeding.
   - When the use/disclosure is necessary for public health activities to prevent or control disease, injury, or disability.
   - When the disclosure relates to victims of abuse, neglect, or domestic violence.
   - When the use/disclosure is related to health oversight activities related to the monitoring, investigating, inspecting, or disciplining those who work here.

- When the disclosure relates to death including information provided to medical examiners, coroners, and funeral directors for identification, determination of the cause of death, or for funeral preparations.
- When the use/disclosure relates to medical research and only after a special approval process.
- When the use/disclosure is to avert a serious threat to health or safety to you or the public.
- When the use/disclosure relates to military, national security, and other government functions.
- When the use/disclosure relates to compliance with worker's compensation programs.
- When the use/disclosure relates to correctional institutions and other law enforcement custodial situations.
- When a person identified by you needs information related to care, payment or notification of your condition.
- When information is shared for disaster relief services such as to the American Red Cross.
- When information is used to provide appointment reminders.
- When information is used to provide you with treatments, services, products or providers in order to manage or coordinate your healthcare.

Required Authorization for Disclosure

Any other use or disclosure of personal health information about you requires your written authorization/informed consent as directed in state and federal statute. Under circumstances other than those stated above, we will ask for you to complete and sign a Consent/Authorization Form in order to use or disclose your personal health information. If you sign this Authorization, you can later cancel this in writing and we will not disclose any further personal health information.

Your Personal Health Information Rights

You have several rights with regard to your personal health information.

You have the right to:

1. Inspect and copy your health information with a reasonable fee charged for copies.
2. Request corrections to your health information through a written response including reasons why the information should be changed. We have the ability to deny your request.
3. Request restrictions on certain uses and disclosures of your health information. We are not required to agree to your requests.
4. Request different ways to communicate with you about personal health information such as contacting you at a particular phone number. Your request must be in writing and we are required to accommodate reasonable requests.
5. Receive a written record of disclosures made of your personal health information up to 6 years before your request (not including disclosures prior to April 14, 2003). We are required to document all disclosures except those noted in the above sections relating to treatment, billing, health care operations and certain other circumstances. Whenever an Authorization form is completed we will document on this list, the date of the disclosure, who received the information, a brief description of he information disclosed, and why the disclosure was made. We must comply within 60 days.
6. Obtain a paper copy of this notice. We will provide a copy no later than the date your first received service from us except in an emergency.

Complaints

Without retaliation, you may file a complaint about our privacy practices with us and with the federal Department of Health and Human Services if you feel your privacy rights have been violated.

This Notice of Privacy Practices is effective on 04/14/2003

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NOTICE OF PRIVACY PRACTICES
CLIENT RETURN RECEIPT

Client's Name: ____
Last First MI

Home Address: ____
____
____

Telephone: ______________________ Date of Birth: ____________

My signature on this form acknowledges that I have received a copy of Clark County Health Department's ***Notice of Privacy Practices***. I understand that this document provides an explanation to me of the ways in which my personal health information may be used or disclosed by the agency and of my rights with respect to my personal health information. I have been provided with the opportunity to discuss concerns that I may have regarding the privacy of my health information.

______________________________ ____________
Client's Signature Date

______________________________ ____________
Client's Representative if Client unable to sign Date

Please return in envelope provided to the Clark County Health Department at the following address:

517 Court Street RM 105
Neillsville, WI 54456-1972

To be completed by Clark County Health Department Staff if Acknowledgement Form is not signed:

1. Was the client given a copy of the Notice of Privacy Practices regarding health information?
   [ ] YES [ ] NO

2. Please explain why the client did not sign this acknowledgement form, and explain the Clark County Health Department's efforts in trying to obtain the client's signature
   ____
   ____

______________________________ ____________
Signature of Health Dept. Staff Date

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INFORMED CONSENT TO RELEASE/OBTAIN HEALTHCARE INFORMATION

CLIENT ____________________ Parent/Guardian ____________________

Medicaid ID# ____________________ ADDRESS ____________________

D.O.B. ____________ AGE ________ ____________________

TELEPHONE ____________________

I consent to release health/social services information, to obtain information from, and/or referral to the party(s) indicated below, including:

- ☐ Referral Information
- ☐ Diagnosis
- ☐ Treatment Plans
- ☐ Outcome of Care
- ☐ Other ____________________

____ Public Health

____ Prenatal Care Coordination EDC:__________

____ Social Services

____ Physician

____ Healthy Birth / St. Joseph's Hospital

____ Family Preservation Program / Children's Service Society of WI

____ Wisconsin Well Woman Program

____ Reproductive Health

____ WIC

____ Birth to Three

____ Other____________________

Do not disclose the following information:

____

____

____

The purpose for such information is to assist in monitoring and coordinating my health care and social service needs.

I understand that I may revoke this consent at any time by notifying the above party(s) and the Clark County Health Department in writing. I also understand that failure to sign this consent will not affect my eligibility for any program offered by the Clark County Health Department.

This authorization shall be valid from the signature date until ____________________.

____________________ SIGNATURE OF CLIENT/RESPONSIBLE PARTY ____________ DATE

____________________ WITNESSED BY ____________ DATE

R.N. Contact Information: Clark County Health Department
517 Court Street Room 105, Neillsville, WI 54456
R.N: ____________ Phone: ____________

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Consent for PNCC Medicaid Billing

☐ You have my permission to bill Wisconsin Medicaid (MA) or private insurance if applicable. I authorize release of information about this claim to Wisconsin Medicaid or my insurance company.

☐ I have not applied for Wisconsin Medicaid (MA) at this time, but I authorize payment of authorized benefits made on my behalf and authorize release of information about this claim to MA should I become eligible in the future.

RRENATAL CARE COORDINATION (PNCC) ADMISSION

This care plan was developed by a Public Health Nurse and me. The purpose of this care plan is to assist me in the deliver of a healthy baby. Assistance will be provided through health education and by other community resources. I can contact my Public Health Nurse to request a change in the plan. I understand that this plan can be changed at any time and as often as necessary. The Public Health Nurse and I will review and update the care plan every 60 days or sooner. If my Public Health Nurse is not available, I can contact the Public Health intake nurse. I was given a business card with information on how to contact my Public Health Nurse.

☐ I wish to participate further in the PNCC program. Frequency of visits will be: ______________

☐ I do not wish to participate further in the PNCC program at this time but understand that I can contact my PHN at any time if I change my mind regarding services.

My signature below indicates that I have read the above, understand it, have had the opportunity to get my questions answered, and consent to care at Clark County Public Health

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Witness Date

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-1105 (02/09)

STATE OF WISCONSIN

FORWARDHEALTH
PRENATAL CARE COORDINATION
PREGNANCY QUESTIONNAIRE

Instructions: Type or print clearly. Before completing this form, read the Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions, F-1105A.

SECTION I — GENERAL INFORMATION

To Be Completed by Health Professional

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member	3. Age — Member

4. Ethnicity ❑ Hispanic ❑ Non-Hispanic

5. Race ❑ American Indian ❑ Black ❑ White ❑ Asian ❑ Hawaiian / Pacific Islander ❑ Other

Lim Eng
A- <20
A- >39
E- H
R- AI,A, B,HPI,O

6. Education (Indicate highest grade completed.)

❑ Primary / Secondary (1-12) _____ ❑ College (1-4 or 5+) _____

7. Marital Status

❑ Single ❑ Married

Edu<12
MS- S

8. Address — Member (Street, City, State, ZIP Code)	9. County

10. Telephone Number — Member	11. Other Telephone Number — Member
12. What is the best way to contact you? When is the best time to contact you?	**13. Name and Telephone Number — Emergency Contact Person**
14. Name — Medical Provider or Clinic (Doctor, Nurse Practitioner, Midwife) ❑ I do not have a medical provider.	**15. Member Identification Number**

16. How many times have you been to a dentist or dental clinic in the last two years?

SECTION II — CURRENT PREGNANCY

1. When is your baby due?

2. What was the date of your last menstrual period?

Tim- L,NAA
PNC- 2,3,N

3. If you could change the timing of this pregnancy, when would you want it?
❑ Earlier ❑ No change
❑ Later ❑ Not at all

4. When was your first medical appointment for prenatal care?
_______ (month / year)
❑ I have not seen anyone yet.
❑ I have an appointment set for __________.
(MM/DD/YY)

5. Your Weight Before Pregnancy _______
Your Current Weight _________
Your Height ________

6. Are you pregnant with more than one baby (Twins, Triplets)?
❑ Yes ❑ No

BMI- <19.8
BMI- $\geq$26.1

7. Are you thinking about breastfeeding your baby?
❑ Yes ❑ No ❑ Undecided

8. Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy?
❑ Yes ❑ No

9. Have you had any bleeding or cramping?
❑ Yes ❑ No

10. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?
❑ Yes ❑ No

WIC- Y

Continued

SECTION III — PREGNANCY HISTORY (If this is a first pregnancy, skip to Section IV.)

1. How many times have you been pregnant before?	2. Number of Full-Term Babies	3. Number of Babies Born More Than Three Weeks Early
4. Number of Miscarriages or Other Pregnancy Losses at 20 or More Weeks	5. Number of Miscarriages or Other Pregnancy Losses Before 20 Weeks	6. Number of Living Children
7. Number of Babies Weighing Less Than 5½ Pounds at Birth	8. Number of Babies Weighing More Than Nine Pounds at Birth	9. Date Last Pregnancy Ended

PreT
Loss 20+
LBW
Int<12m

10. Outcome of Last Pregnancy ❑ Live Birth ❑ Miscarriage / Other Loss

SECTION IV — CONCERNS

1. Do you have, or have you ever had, any of the following conditions? ❑ Yes ❑ No
   Check all that apply.
   - ❑ Asthma.
   - ❑ Chlamydia, gonorrhea, syphilis, or genital herpes.
   - ❑ Diabetes.
   - ❑ High blood pressure.
   - ❑ Seizures / epilepsy.
   - ❑ Urinary tract infection.
   - ❑ Other illness, infection, or condition requiring medical care.
2. Do you have dental pain or bleeding gums when you eat or brush your teeth? ❑ Yes ❑ No
3. Before pregnancy, did you smoke cigarettes? ❑ Yes ❑ No
   If Yes, indicate the average number of cigarettes smoked per day. ________
4. Since you have been pregnant, have you smoked cigarettes? ❑ Yes ❑ No
   If Yes, indicate the average number of cigarettes smoked per day. ________
5. Does anyone in your household smoke? ❑ Yes ❑ No
6. In the three months before your current pregnancy, did you use any form of alcohol? ❑ Yes ❑ No
   If Yes, indicate the average number of drinks consumed per week. ________
7. Since you have been pregnant, have you used alcohol? ❑ Yes ❑ No
   If Yes, indicate the average number of drinks consumed per week. ________
8. In the past year, have you used street drugs? ❑ Yes ❑ No
9. Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you? ❑ Yes ❑ No
10. Do you feel unsafe where you live? ❑ Yes ❑ No
11. During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food? ❑ Yes ❑ No
12. Have you had any housing problems in the past three months? ❑ Yes ❑ No
13. Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments? ❑ Yes ❑ No
14. Have you had problems with depression or received counseling or medications for mental health concerns? ❑ Yes ❑ No
15. During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑ No
16. How do you rate your current stress level? ❑ High ❑ Medium ❑ Low
17. How many people can you count on when you need help? ❑ 0 ❑ 1-2 ❑ 3+

1 — Y
2 — Y
4 — Y
7 — Y
8 — Y
9 — Y
10 — Y
11 — Y
12 — Y
13 — Y
14 — Y
15 — Y
16 — H
17 — 0

Continued

SECTION IV — CONCERNS (Continued)

18. Which of these things worry you a lot? Check all that apply.
    - ☐ Money problems.
    - ☐ My job.
    - ☐ My partner's job or unemployment.
    - ☐ My partner's drinking or drug use.
    - ☐ My own drinking or drug use.
    - ☐ My partner is in jail.
    - ☐ My relationship with my partner.
    - ☐ My partner did not want this pregnancy.
    - ☐ Labor and delivery.
    - ☐ Caring for this baby.
    - ☐ Caring for my other children.
    - ☐ Other ______________________.

19. What worries you the most?

20. What do you do to deal with your problems?

21. Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?

22. What topics would you like to learn more about? Check all that apply.
    - ☐ Baby's growth and development.
    - ☐ Breastfeeding.
    - ☐ Caring for your newborn.
    - ☐ Family planning / birth control.
    - ☐ Getting health care for you and your baby.
    - ☐ How to stop smoking.
    - ☐ Effects of alcohol on mother and baby's health.
    - ☐ Labor and delivery.
    - ☐ Managing the discomforts of pregnancy.
    - ☐ Nutrition during pregnancy.
    - ☐ Managing stress.
    - ☐ Other ______________________.

23. Additional Information

SECTION V — TO BE COMPLETED BY HEALTH PROFESSIONAL

Is the member eligible for Prenatal Care Coordination (PNCC) services?

☐ Yes, based on a number of factors ______________ or age________.

☐ No.

SIGNATURE — Staff Completing Assessment	Date Signed
SIGNATURE — Qualified Health Professional (If Different from Above)	Date Signed

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SPHERE INFORMATION

Date of Assessment:_____/_____/_______ This is: ☐ Initial Assessment ☐ Updated Information

SPHERE ID #: ____________________

Last Name		
First Name		
Middle		
Maiden		
DOB		
Gender	M F	
WIC ID #		
Ethnicity	☐ Non-Hispanic ☐ Hispanic	
Race	☐ White ☐ American ☐ Indian/Native Alaskan ☐ Asian ☐ Black ☐ Hawaiian/Pacific Island ☐ Other ☐ Unknown	**CLIENT OR FF #:**_________

CONTACT INFORMATION
☐ DO NOT CONTACT
Mailing Address:
Home Address (if not the same)
County:
Pre 1950 Housing? ☐ YES ☐ NO ☐ UNKNOWN
TELEPHONE: **Location:** home work friend relative other Best time to contact: Cell Phone: Email Address: ☐ DO NOT CONTACT

HEALTH CARE COVERAGE

Health Care Coverage? YES NO UNKNOWN	**Dental Coverage?** YES NO UNKNOWN
Coverage Type: *Badger Care------MA#:____________________ *MA----------------MA#:____________________ *MA / FP Waiver *MC *Other Health Coverage *Private Health Insurance *Private Insurance w/health condition restriction	**Coverage Type:** *Badger Care-------MA#____________________ *MA----------------MA#____________________ *MA / FP Waiver *MC *Other Health Coverage *Private Health Insurance *Private Insurance w/health condition restriction
Does client have Primary Care Provider? YES Name: NO UNKNOWN	**Does Client Have a Dentist or Oral Health Provider?** YES Name: NO UNKNOWN
Name of Regular Health Care Site	**Name of Dentist**

SPHERE INFORMATION

Does Client Smoke? YES NO UNKNOWN	**Exposure to Second Hand Smoke?** YES NO UNKNOWN	**If yes, where was exposure?** □ house □ auto □ job □ other
Is client pregnant or within 60 days of a birth or other pregnancy loss? (mom) YES NO UNKNOWN		
Does client have a chronic medical, behavioral, emotional, or other health condition that has lasted or is expected to last 12 months or more? YES -What:________________ NO UNKNOWN **IF YES: Complete the following:** Receive SSI: YES NO UNKNOWN Has client been diagnosed by health care provider? YES NO UNKNOWN Primary DX ICD-9 Code: Secondary DX ICD-9 Code:		
Is client vision impaired? Y N UNKNOWN **If yes: need assistance?** Y N	**Is client hearing impaired?** Y N UNKNOWN **If yes: need interpreter?** Y N	

GENERAL / MORTALITY		
Interpreter needed? Y N	**If yes, language:**	**Interpreter provided by:** Local staff contracted friend/family
Education Level <9th grade 9-12th grade – No Diploma HS Graduate or Equivalent Some college – no diploma Associate Degree Bachelor's Degree Graduate or Professional Degree *currently enrolled in any educational training programs: Y N *if Yes, full or part time *If No, currently working on any of the following? Y N • Planning or preparing for educational activities • Researching jobs • Researching educational experiences • Applying for financial aid • Obtaining state identification	**Employment Status:** *Full time: >35 hours/week *Part time: 14-34 hours/week *Occupation: *Unemployed & actively seeking work *Unemployed & not actively seeking work	**Marital Status:** *Single *Single and never married *Boyfriend/Girlfriend *Engaged *Married *Separated *Divorced *Widowed Currently living with significant other? Y N

Significant Contact Person:
- First:
- Last:
- Relationship to Client:
- Phone:

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PNCC Psychosocial Assessment Checklist

	1st (0-14 weeks)	2nd (16-27 weeks)	3rd (28-40 weeks)	Postpartum
1. Assessment Date	___/___/___	___/___/___	___/___/___	___/___/___
2. Poor attitude regarding pregnancy	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
3. Poor previous pregnancy experience	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
4. Poor support system	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
5. Drugs/alcohol/tobacco use	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
6. Religious/ethnic/cultural factor affecting pregnancy	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
7. Conflict/violence in home	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
8. Unable to get prenatal care	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
9. Family has urgent health needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
10. Insufficient funds for food	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
11. Difficulty obtaining food stamps	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
12. Difficulty enrolling in WIC	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
13. Child Care needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
14. Housing needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
15. Transportation needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
16. School needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
17. Employment needs	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
18. Child support difficulty	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
19. Primary OB/GYN identified	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
20. Client has providers contact information	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
21. Client identifies procedure for obtaining medical information or care after hours	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
22. Client identified appropriate situation to use the ER	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N

23. Client knows how to schedule, cancel and reschedule medical appointments	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
24. Client identified primary care provider for infant	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
25. Client displays adequate knowledge in obtaining adequate and reliable childcare.	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
26. Client Strengths				
27. Client Weaknesses				
28. Actual and Potential Stressors				

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________________ Address: ______________________

Your Date of Birth: ____________________ ______________________

Baby's Date of Birth: ____________________ Phone: ______________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by ______________________ Date ______________________

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Clark County Health Department

517 Court St., Room 105 * Neillsville, WI 54456-1972 * (715)743-5105 * Toll Free 1-877-743-5105 * Fax (715)743-5115

http://www.co.clark.wi.us/

PNCC Prenatal/Postpartum Health Education Topic Checklist

Client's Name: ______________________________

	Date Info Given/Education Provided	RN Initials	Not Applicable
Helpful Programs in Clark County			
Clark County Family Resource Guide			
*RN-Care Coordinator's Contact Information			
*Importance of Continuous Prenatal Care			
*Recommended Weight and Weight Gain Goals			
*Recommended Dietary Intake and Meal Patterns			
*Use of prenatal vitamins, how to improve intake of calcium rich foods, iron rich foods, folate rich foods			
*Avoidance of self-imposed diets and food practices that can be harmful			
*Dietary interventions for common problems of pregnancy including nausea/vomiting, heartburn, and constipation			
*Safe water source-refer for testing if private well has not been tested in the last year			
Infant Growth and Development (Weeks 1-12)			
*Depression Info and Screening (First Trimester)			
Infant Growth and Development (Weeks 13-19)			
Infant Growth and Development (Weeks 19-26)			
*Depression Info and Screening (Second Trimester)			
Infant Growth and Development (Weeks 27-40)			
*Depression Info and Screening (Third Trimester)			
Stress and Pregnancy; Relaxation Techniques			
*Dangers of over-the-counter medicines, prescription drugs, tobacco, alcohol, illicit drug use (First Trimester)			
Self help strategies for common discomforts related to pregnancy			
Self care during pregnancy			
Danger signs and symptoms of pregnancy-bleeding, infections during pregnancy, emergency arrangements			
Promotion and Support of Breastfeeding			
Signs and symptoms of preterm labor			
Oral Health and Pregnancy			
Labor and Delivery + true vs. false labor + timing of contractions			
Father Information			
Parenting			
Hospital Arrangements-support person during labor and delivery			
Preparation for baby-nursery checklist			

	Date Info Given/Education Provided	RN Initials	Not Applicable
Lead			
Radon			
Fire Safety/Smoke Detectors			
Carbon Monoxide			
Car Seat Safety			
Infant Safe Sleep Practices/SIDS			
Shaken Baby Syndrome			
Visual Assessment of Infant's Sleeping Environment			
*Depression Info/Screening (Postpartum)			
*Personal hygiene			
*Nutrition during breastfeeding; including influence of tobacco, alcohol, and other drugs or nutrition if formula feeding			
*Guides to successful breastfeeding, breast care, and routine self-breast checks			
*Physical Activity			
*Recognition of minor gynecologic problems			
*Contraceptive Methods			
*Prevention of Sexually Transmitted Infections			
*Continuity of basic primary and reproductive health care			
*Infant's hunger and fullness cues			
*Infant nutrition and appropriate feeding practices			
*Successful breastfeeding			
*Food and/or formula preparation and storage			
*Bathing, skin and cord care, and diaper rash prevention			
*Normal growth and development			
*Taking infant's temperature, treatment of nausea, vomiting, diarrhea, dehydration, and fever			
*Infant nurturing and stimulation			
*Effects of secondhand smoke on infant health and nutrition			
*Injury prevention and safety, including car seats, falls, poisoning, choking, and sleep positions			
*Appropriate use of infant's primary health care provider versus the emergency room			

Required to assess/provide education on

Videos	Date Given to Client	Date Returned to Health Dept.
Breastfeeding: You Can Do It		
Laugh and Learn About Childbirth		
The Best for Baby		
The Happiest Baby on the Block		

Public Health
Prevent. Promote. Protect.

Clark County Health Department

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http://www.co.clark.wi.us/

Summary of Referrals:	Date of Referral	R.N. Initials	Date of Follow-up	Has Benefit? Yes/No	Entered into Sphere? Yes/No	Client Eligible
Nutrition:						
WIC Program						
Dietician: Nutritional Needs						
Food Share Program						
Food Pantries/Emergency Foods						
Free and Reduced Lunch Program						
HealthCare:						
Primary Care Provider						
Prenatal Care						
Lactation Services						
Urgent Care						
Mental Health Services						
Alcohol/Drug Abuse Services						
Family Health Center (FHC)-Marshfield Clinic						
Local Health Department:						
Car Seats for Kids Program						
Cribs for Kids Program						
Financial- Family Planning Only Services						
Immunization Services						
Interpreter Services						
Lead-Lead Hazard Reduction						
Prenatal Care Coordination (PNCC)						
Clark County Reproductive Health Services						
Well Water Testing Program						
Radon Testing						
Social Services:						
Child Abuse/Neglect						
WI Home Energy Assistance						
Badger Care Access						
Oral Health Care:						
Oral Health-Dentist						

Summary of Referrals:	**Date of Referral**	**R.N. Initials**	**Date of Follow-up**	**Has Benefit? Yes/No**	**Entered into Sphere? Yes/No**	**Client Eligible**
Tobacco:						
First Breath Program						
WI Tobacco Quit Line						
Tobacco Addiction-Other Services						
Community Services:						
Alcohol and Drug Counseling						
Mental Health Counseling						
Personal Development Center:						
Clark County Domestic Violence						
Abuse Shelters						
Domestic Violence Services						
Miscellaneous:						
Adoption Services						
Infant Death Center of Wisconsin						
Child Care Services-Childcare Referral and Resource Center						
Hannah Center						
Birth to Three Program						
Child Protective Services						
Clothing						
Job Training						
Transportation						
CYSHCN						
Housing						
Parenting Services						

Infant Assessment

(Rev 01/2012)

SECTION I - Client Information

Name: Date of Birth: Age:

SPHERE ID: Assessment Date:

Mother's Name: DOB: SPHERE ID:

SECTION II - Birth Information

1. Birth Facility Name:

2. Birth Facility Type:
___Birth Center ___Clinic/Dr. Clinic
___Hospital ___Residence ___Other

3. Birth Facility Location:
a) USA: ○ Yes ○ No ____________
b) State: ____________
c) County: ____________
d) Type: ___City of ___Town of ___Village of ____________

4. Birth Attendant Title:
___M.D. ___D.O. ___C.N.M. ___Other Midwife
___Other ___Unknown

5. Was baby transfered? (If no, skip to question 9)
○ Yes ○ No ○ Unknown

6. Date baby was transferred:
____/____/________

7. Facility transferred to:

8. Location of transfer facility:

9. Was baby in NICU? (If no, skip to question 11)
○ Yes ○ No ○ Unknown

10. # of days in NICU:
____days ☐ Unknown

11. Birth Weight:
____lb. ____oz.

12. Birth Length:
____In. ____/8 Inch

13. Birth Order/Plurality:
____of ____ (e.g. 1 of 1)

14. Apgar Scores:
____5 min ____ 10 min

15. Gestational Age:
____Wks. Unknown

16. Are there any abnormal conditions of the newborn: (Check all that apply) ○ Yes ○ No

- ☐ Anemia (Hct., 39/Hgb.<13)
- ☐ Antibiotics
- ☐ Assisted Ventilation Immediately Following Delivery
- ☐ Assisted Ventilation for More Than 6 Hours
- ☐ Hyaline Membrane Disease/RDS
- ☐ Meconium Aspiration Syndrome
- ☐ NICU Admission
- ☐ Other Specify ____________
- ☐ Seizure or Serious Neurologic Dysfunction
- ☐ Significant Birth Injury
- ☐ Surfactant Replacement Therapy

17. Does the newborn have any congenital anomalies? (Check all that apply) ○ Yes ○ No

- ☐ Anencephalus
- ☐ Spina Bifida/Meningocele
- ☐ Hydrocephalus
- ☐ Microcephalus
- ☐ Other Central Nerv. Sys. Anomalies
  Specify:____________
- ☐ Cyanotic Congenital Heart Disease
- ☐ Heart Malformations
- ☐ Other Circulatory/Respiratory Anomalies
  Specify:____________
- ☐ Rectal Atresia/Stenosis
- ☐ Tracheo-esophageal Fistula/Esophageal Atres
- ☐ Other Urogenital Anomalies
  Specify:____________
- ☐ Cleft Lip/Palate
  - ☐ Cleft Lip with or without Cleft Palate
  - ☐ Cleft Palate alone
- ☐ Limb Reduction defect
- ☐ Polydactylly/Syndactyly/Adactyly
- ☐ Club Foot
- ☐ Congenital Diaphragmatic Hernia
- ☐ Other Musculoskeletal/Integumental Anomalies
  Specify:____________
- ☐ Down Syndrome

(17. Continued)

- ☐ **Omphalocele/Gastroschisis**
  - ☐ **Omphalocele**
  - ☐ **Gastroschisis**
- ☐ **Other Gastrointestinal Anomalies**
  - **Specify:**________________
- ☐ **Malformed Genitalia**
  - ☐ **Hypospadias**
- ☐ **Renal Agenesis**
- ☐ **Down Syndrome - Karyotype Confirmed**
- ☐ **Down Syndrome - Karotype Pending**
- ☐ **Suspected Chromosomal Disorder**
- ☐ **Suspected Chromosomal Disorder - Karyotype confirmed**
- ☐ **Suspected Chromosomal Disorder - Karyotype pending**
- ☐ **Other Chromosomal Anomalies**
  - **Specify:**________________
- ☐ **Other Congenital Anomalies (not listed)**
  - **Specify:**________________

SECTION III - Current Health Information

1. Does your baby have a primary care provider?
   ○ **Yes** ○ **No** ○ **Unknown**

2. Name of primary care provider:

3. Usual site for baby's routine health care: (If unknown, skip to question 5)

- ___**Unknown**
- ___**Community/Neighborhood Health Center**
- ___**Doctor's Office/Clinic**
- ___**FP/RH Clinic**
- ___**Hospital Emergency Room**
- ___**Local Health Department**
- ___**Migrant Health Clinic**
- ___**Tribal Clinic**
- ___**Other** ________________

4. Usual health care site name:

5. Current Weight: ____**lb.** ____**oz.**

6. Current Length: ____**In.** ____**/8 Inch**

7. Weight/ Length Percentile:

8. Weight/ Age Percentile:

9. Length/ Age Percentile:

10. Head Circumference: ____**Cm.**

11. Head Circumference Percentile:

12. Immunization Status:

- ○ **The baby is complete on all vaccines (Pink in WIR)**
- ○ **Currently needs recommended vaccines or is overdue for age on vaccines (Green/Blue in WIR)**
- ○ **Baby has waiver for health, religious, or personal conviction reasons from all recommended vaccines.**
- ○ **Baby has waiver for health, religious, or personal conviction reasons from one or more recommended vaccines and is up-to-date on the other vaccines.**
- ○ **Baby has waiver for health, religious, or personal conviction reasons from one or more recommended vaccines and needs other recommended vaccines not waived or is overdue for age on vaccines not waived.**

13. Reasons overdue: (Check all that apply)

- ☐ **Illness/Medical Reason**
- ☐ **Transportation Barrier**
- ☐ **Work/Clinic Schedule Barrier**
- ☐ **Other** ________________

14. Immunization Status Verification: (Check all that apply)

- ☐ **Immunization Card**
- ☐ **WI Immunization Registry (WIR)**
- ☐ **Called MD/Provider**

15. Completed Baby Health Exams (Well Visits):

- ☐ **1st Week**
- ☐ **1 Month Exam**
- ☐ **2 Month Exam**
- ☐ **4 Month Exam**
- ☐ **6 Month Exam**
- ☐ **9 Month Exam**
- ☐ **12 Month Exam**
- ___ **Total Completed**

16. Baby Health Exams Status (for current age):

- ○ **The baby is up-to-date for age on all health exams**
- ○ **The baby needs or is past due for their last recommended health exam for their age.**

17. Reasons past due: (Check all that apply)

- ☐ **Illness/Medical Reason**
- ☐ **Transportation Barrier**
- ☐ **Work/Clinic Schedule Barrier**
- ☐ **Other** ________________

18. Emergency room visits - has the baby been to the emergency room since the last assessment: ○ **Yes** ○ **No**

#of times_______**Medical Illness** **#of times**_______**Physical Injury**

19. Injuries - has the baby been had any injuries since the last assessment: (Check all that apply) ○ Yes ○ No

- ☐ Bites/Stings
- ☐ Burns
- ☐ Child Passanger Safety
- ☐ Choking
- ☐ Cuts/Sharp Objects
- ☐ Drowning/Water Safety
- ☐ Falling Objects
- ☐ Falls
- ☐ Fire Related
- ☐ Guns/Firearms
- ☐ Poisoning/Chemical Exposure
- ☐ Suffocation
- ☐ Other ____________________

20. Does the baby have any medical risk factors: (Check all that apply) ○ Yes ○ No ○ Not Assessed

- ☐ Anemia
- ☐ Asthma
- ☐ Bottle Tooth Decay
- ☐ Birthweight-LBW (<5# 8oz)
- ☐ Birthweight - VLBW (<3# 5oz)
- ☐ Blood Lead >10mcg/dl
- ☐ Breastfeeding Problem
- ☐ Bronchitis
- ☐ Cardiac Murmor
- ☐ Cerebral Palsy
- ☐ Chronic Constipation
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Failure to thrive
- ☐ Fetal Alcohol Syndrome
- ☐ Food Allergy
- ☐ Genetic Disorder
- ☐ Gestational Age - LGA (>9#)
- ☐ Gestational Age - SGA
- ☐ HIV/AIDS
- ☐ Head Circumference <5th %
- ☐ Head Circumference >95th %
- ☐ Inadequate Weight Gain
- ☐ Inborn Error of Metabolism
- ☐ Jaundice
- ☐ Lactose Intolerance
- ☐ Low Length for Age
- ☐ Meningitis
- ☐ Otitis Media
- ☐ Prenatal Alcohol Exposure
- ☐ Prenatal Drug Use
- ☐ Prenatal STI Exposure
- ☐ Preterm <=37 Weeks Gestation
- ☐ Seizures
- ☐ Tuberculosis Disease
- ☐ Tuberculosis Infection
- ☐ Vaccine Adverse Reaction

SECTION IV - Sleep Environment

1. How is baby put to bed?
○ Lateral (Side) ○ Prone (Stomach) ○ Supine (Back) ○ Not Assessed

2. Is baby offered a pacifier when placed to sleep?
○ Yes ○ No ○ Not Assessed

3. Are there any concerns with the sleep environment? (Check all that apply) ○ Yes ○ No ○ Not Assessed

- ☐ Co-sleeps w/parent(s) or other children
- ☐ Crib location - not near parent/caregiver
- ☐ Inappropriate objects used in or near crib
- ☐ Baby does not have a crib
- ☐ Other crib safety concerns
  Specify ________________
- ☐ Other Sleep environment concenrns
  Specify ________________
- ☐ Overheated (room temperature)
- ☐ Sleeps on couch

SECTION V - Home Environment

1. Is baby exposed to 2nd hand smoke? (Check all that apply)
○ Yes ○ No ○ Not Assessed
- ☐ Household
- ☐ Automobile
- ☐ Occupational
- ☐ Other ________________

2. Are there smoke detector concerns? (Check all that apply)
○ Yes ○ No ○ Not Assessed
- ☐ Not Installed
- ☐ Not Working Correctly
- ☐ Incorrectly Placed
- ☐ Other ________________

3. Are there any lead hazard concerns? (Check all that apply)
○ Yes ○ No ○ Not Assessed
- ☐ Pre-1978 Housing
- ☐ Peeling or Chipping Paint
- ☐ Evidence of Water Damage
- ☐ Other ________________

4. Does your baby use a car seat?
○ Yes ○ No ○ Not Assessed

SECTION VI - Breastfeeding/ Formula

1. Is your baby on WIC?
   - ○ Yes ○ No ○ Not Assessed
   - If no, why: ○ Not Eligible ○ Appointment Scheduled ○ Parent/ Guardian Refused

2. How are you feeding your baby?
   - ○ Exclusively breastfeeding
   - ○ Breastfed with formula supplement
   - ○ Formula Only
   - ○ Cow's milk
   - ○ Other ______________

3. If breastfed, is baby on vitamin D supplement? ○ Yes ○ No

4. Is breastfeeding going well for your baby? ○ Yes ○ No
   - ☐ Difficulty latching on ☐ Jaundice ☐ < 6 wet diapers/day
   - ☐ Weak/Ineffective suck ☐ Inadequate Stooling ☐ Other ______________

5. Was baby ever breastfed?
   - ○ Yes ○ No ○ Not Assessed
   - If yes, how long? Still Breastfeeding
   - Days: 1 2 3
   - Weeks: 1 (4-10 days) 2 (11-17 days) 3 (18-24 days) 4 (25-31 days)
   - Weeks: 5 (32-38 days) 6 (39-45 days) 7 (46-52 days)
   - Months: 2 3 4 5 6 7 8 9 10 11 12

6. What are the reasons you stopped breastfeeding? (Check all that apply)
   - ☐ Disinterested ☐ Milk Supply Concerns
   - ☐ Illness/ Baby ☐ Quit: Goal Met
   - ☐ Illness/ Mom ☐ Sore Nipples/Engorgement
   - ☐ Inadequate Weight Gain ☐ Weak or Ineffective Suck
   - ☐ Jaundice ☐ Work/ School Schedule
   - ☐ Lack of Support ☐ Other ______________

7. Do you recognize when baby is hungry or full? (Check all that apply) ○ Yes ○ No ○ Unknown
   - Hunger:
     - ☐ Sucks on hand
     - ☐ Turns to root and makes sucking motion
     - ☐ Opens Mouth
     - ☐ Reaches for food
     - ☐ Other______________
   - Full:
     - ☐ Lets go of nipple
     - ☐ Turns head away
     - ☐ Won't Open Mouth
     - ☐ Other______________

8. How often do you feed your baby in 24 hours? ☐ Unknown
   - # of breastfeedings ____ Ounces per Bottle ____
   - # of formula feedings ____ Total Oz per day consumed ____

9. When did baby first receive formula? ☐ Unknown
   - Days: 1 2 3
   - Weeks: 1 2 3 4 5 6 7
   - Months: 2 3 4 5 6 7 8 9 10 11 12

10a. If formula fed, what kind of formula is baby taking?
   - ☐ Powder
   - ☐ Concentrate
   - ☐ Ready-to-Feed

10b. What type of formula is used? ☐ Unknown
   - ○ Iron Fortified Formula
   - ○ Low Iron Formula without Iron Supplement
   - ○ Low Iron formula with Iron Supplement
   - ○ Special Formula ______________

11. Tell me how you make and store formula:
   - Preparation ○ Proper ○ Improper
   - Dilution ○ Proper ○ Improper
   - Storage ○ Proper ○ Improper

12a. What is your baby's main source of drinking water?
   - ○ City or rural water system
   - ○ Private Well
   - ○ Bottled

12b. If well water:
   - ○ Tested in last year - SAFE
   - ○ Tested in last year - UNSAFE
   - ○ NOT TESTED in last year
   - ○ Unknown

12c. Is the water fluoridated? ○ Yes ○ No ○ Don't Know

SECTION VII - Bottle/Cup

1. What is put in baby's bottle? (Check all that apply)
   - ☐ No Bottle Use ☐ Cereal ☐ Juice ☐ Milk ☐ Water
   - ☐ Breast Milk ☐ Formula ☐ Karo Syrup ☐ Sweetened Beverage ☐ Other______________

2. Do you:

Put baby to bed with a bottle: ○ Yes ○ No ○ Unknown
Prop baby's bottle: ○ Yes ○ No ○ Unknown

3. Does your baby drink from a cup?

○ Yes ○ No ○ Unknown

If yes: ☐ Cup or glass ☐ Spill-proof ☐ Training cup w/lid

4. At what age did your baby stop using a bottle:

Unknown | Never bottle fed | Still using bottle | Months: 1 2 3 4 5 6 7 8 9 10 11 12

SECTION VIII - General Feeding

1. At what age did baby first get:

Baby Cereal?	○ None Yet	○ <4 months	○ >= 4 months to < 6 months	○ >=6 months	○ Unknown
Baby Food?	○ None Yet	○ <4 months	○ >= 4 months to < 6 months	○ >=6 months	○ Unknown
Baby Juice?	○ None Yet	○ <4 months	○ >= 4 months to < 6 months	○ >=6 months	○ Unknown
Finger Foods?	○ None Yet	○ <4 months	○ >= 4 months to < 6 months	○ >=6 months	○ Unknown

2. How much fruit juice is baby drinking every day?

○ No Juice
○ <= 10 oz./day of juice
○ > 10 oz./day of juice

3. How much sweetened beverages is baby drinking every day?

○ No Sweetened Beverages
○ <= 10 oz./day sweetened beverages
○ > 10 oz./day sweetened beverages

4. Are feeding practices appropriate for the baby? (Check all that apply) ○ Yes ○ No ○ Not Assessed

☐ Feeding Schedules
☐ Fed potentially contaminated foods (honey, food chewed by caregiver, uncooked hotdogs or deli meats, etc.)
☐ Foods with choking risk
☐ Forcing to eat
☐ Inappropriate foods/textures for developmental stage
☐ Infant's diet very low in calories or essential nutrients (e.g., Vegan, macrobiotic)
☐ Not supporting needs for self-feeding progression
☐ Other ____________

5. Did your family have any problems getting enough food last month?

○ Yes ○ No ○ Don't know/Refused ○ Not Assessed

6. Is your family participating in any food programs? (Check all that apply) ○ Yes ○ No ○ Not Assessed

☐ Food Share/Food Stamps
☐ Commodity Program
☐ Food Pantry
☐ Food at Day Care (CACFP)
☐ SHARE
☐ WIC
☐ Free/Reduced Price School Lunch
☐ Early Headstart/Headstart

7. Does your baby take any vitamins, minerals, herbs or herbal supplements? (Check all that apply) ○ Yes ○ No

☐ Fluoride
☐ Herbal Supplements
☐ Infant Multivitamin
☐ Iron
☐ Vitamin D
☐ Other ____________

SECTION IX - Psychosocial Risk Factors

1. Does baby or household members have any psychosocial risk factors? (Check all that apply)

○ Yes ○ No ○ Not Assessed

Housing:

- ☐ Homeless (including shelter, hotel/motel)
- ☐ Housing problems

Household

- ☐ Household member with alcohol abuse
- ☐ Household member with street drug use
- ☐ Household member with gang involvement
- ☐ Household member with correctional system involvement
- ☐ Household violence/intentional injury

Mother:

- ☐ Mother < 12 grade education
- ☐ Mother < 18 years
- ☐ Mother non English speaking
- ☐ Mother upset/unhappy about birth of baby
- ☐ Mother with developmental delay
- ☐ Mother with high stress level
- ☐ Mother with HX mental health concerns
- ☐ Mother with no social support, isolated or alone
- ☐ Mother with physical disablilty
- ☐ Mother with symptoms of depression
- ☐ Concern with mother's ability to respond to infant demands/crying

Infant:

- ☐ Child Abuse/Neglect
- ☐ Infant Foster Care/Kinship Care
- ☐ Infant with mental health concerns
- ☐ Infant with social/emotional developmental concerns

Father/Partner:

- ☐ HX of emotional or verbal abuse by father of baby or partner
- ☐ HX of physical abuse by the father of baby or partner
- ☐ Father/partner upset/unhappy about baby

Barriers:

- ☐ Child care problems
- ☐ Limited access to nutritious and safe food
- ☐ Migrant
- ☐ Poverty
- ☐ Transportation problems
- ☐ HX of extended unemployment

SECTION X - Health Teaching Topics

SECTION XI - Assessed Risk(s):

Postpartum Assessment

Type of Visit: ☐ **Intial** ☐ **On-going** **Visit Date:** ___/___/______

SPHERE ID: ____________ **Client Name:** ______________________________ **DOB:** ___/___/______

Section I - Pregnancy Information

1. During your pregnancy, did you take a supplement that contains folic acid? ○ Yes ○ No ○ Unknown
1a. If yes, trimester began taking supplement? ○ 1st Trimester ○ 2nd Trimester ○ 3rd Trimester ○ Client Unsure

2. During your pregnancy, did you have gestational diabetes? ○ Yes ○ No ○ Unknown

3a. During your pregnancy, how many times were you treated for Urinary Tract Infection (UTI)?
○ None ○ Once ○ Twice ○ Three or more ○ Unknown
3b. After treatment, were you tested to see if you were cured? ○ Yes ○ No ○ Unknown
3c. If yes, how many times? ○ Once ○ Twice ○ Three or more ○ Unknown

4a. During your pregnancy, how many times were you treated for Sexually Transmitted Infection (STI)?
○ None ○ Once ○ Twice ○ Three or more ○ Unknown
4b. After treatment, were you tested to see if you were cured? ○ Yes ○ No ○ Unknown
4c. If yes, how many times? ○ Once ○ Twice ○ Three or more ○ Unknown

5. During your pregnancy, how many times did you take antibiotics for any type of infection other than UTI or STI?
○ None ○ Once ○ Twice ○ Three or more ○ Unknown

6. During your pregnancy did you receive the following services?

- **WIC** ○ Yes ○ No ○ Unknown

If yes, for how many months? [1] [2] [3] [4] [5] [6] [7] [8] [9] [Unknown]

If no, why?
○ Not eligible
○ Unable to get or keep an appointment
○ Refused
○ Awaiting other agency response
○ Lack of client follow through

- **Medicaid/BadgerCare Plus** ○ Yes ○ No ○ Unknown

If yes, for how many months? [1] [2] [3] [4] [5] [6] [7] [8] [9] [Unknown]

If no, why?
○ Not eligible
○ Unable to get or keep an appointment
○ Refused
○ Awaiting other agency response
○ Lack of client follow through

- **Food Share/Food Commodities** ○ Yes ○ No ○ Unknown

If yes, for how many months? [1] [2] [3] [4] [5] [6] [7] [8] [9] [Unknown]

If no, why?
○ Not eligible
○ Unable to get or keep an appointment
○ Refused
○ Awaiting other agency response
○ Lack of client follow through

• **TANF (Temporary Assistance for Needy Families - also known as W2)/Welfare** ○ Yes ○ No ○ Unknown

If yes, for how many months? [1] [2] [3] [4] [5] [6] [7] [8] [9] [Unknown]

If no, why? ○ Not eligible

○ Unable to get or keep an appointment

○ Refused

○ Awaiting other agency response

○ Lack of client follow through

7. Did you attend a child birth education class? ○ Yes ○ No ○ Unknown

Number of births or pregnancy losses from current pregnancy: [ ]

Birth 1

Name: First [ ] Last [ ]

DOB or date pregnancy ended [/ /] (mm/dd/yyyy)

Pregnancy Outcome: ○ Live Birth ○ Live Birth, died 0-27 days ○ Live Birth, died 28-265 days ○ Miscarriage/Other Pregnancy Loss ○ Stillborn ○ Unknown

Type of delivery: ○ Vaginal ○ Cesarean

Birth Weight: [ ] lb. [ ] oz.

Gestational Age: [ ] weeks

Days in NICU: [ ] day(s)

Apgar Score: 5 Minute: [ ]

Is baby on WIC? ○ Yes ○ No ○ Unknown ○ Not Applicable

If no, why? ○ Not Eligible

○ Appointment scheduled

○ Parent/Guardian Refused

How is baby being fed? ○ Exclusively breastfeeding

○ Breastfed with formula supplement

○ Formula Only

○ Cow's Milk

○ Other [ ]

○ Not Applicable

Was baby ever breastfed? ○ Yes ○ No ○ Unknown ○ Not Applicable

If yes, how long? ○ **Still breastfeeding** *or specify:* _____*Day(s)* _____*Week(s)* _____*Month(s)*

How is baby put to bed? ○ Lateral (Side) ○ Prone (Stomach) ○ Supine (Back) ○ Unknown ○ Not Applicable

Is baby offered a pacificer when placed to sleep? ○ Yes ○ No ○ Not Assessed ○ Not Applicable

Are there any concerns with the sleep environment? ○ Yes ○ No ○ Unknown ○ Not Applicable

If yes, check all that apply:

- ☐ Bed shares w/parent(s) or other children
- ☐ Crib location - not near parent/caregiver
- ☐ Inappropriate objects used in or near crib
- ☐ Baby does not have a crib
- ☐ Other crib safety concerns Specify: ______
- ☐ Other sleep environment concerns Specify: ______
- ☐ Overheated (room temperature)
- ☐ Sleeps on couch

Is the father involved in the care of the baby? ○ Yes ○ No ○ Not Applicable

Is another family member the guardian of the baby? ○ Yes ○ No ○ Unknown ○ Not Applicable

Baby in foster home placement? ○ Yes ○ No ○ Unknown ○ Not Applicable

Baby placed up for adoption? ○ Yes ○ No ○ Unknown ○ Not Applicable

Add Separate Sheet for each Additional Birth Record

Section II - Postpartum Information

1. Total weight change during this pregnancy:

○ Gain ○ Loss ______ lb. ______ oz.

Weight before pregnancy ______ lb. ______ oz.

Height: ______ ft. ______ in.

BMI: ______

2. Total number of prenatal medical visits: ______

3. Do you have a primary care provider? ○ Yes ○ No ○ Unknown

3a. Name of Primary Care Proivder: ______

3b. Usual site for routine health care:

○ Community/Neighborhood Health Center

○ Doctor's Office/Clinic ○ FP/RH Clinic ○ Hospital Emergency Room ○ Local Health Department

○ Migrant Health Clinic ○ Other ○ Tribal Clinic ○ Unknown

3c. Usual health care site name: ______

3d. Postpartum Medical Visit? ○ Yes ○ No ○ Unknown

3e. If Yes: ○ Within 6 weeks ○ 7-8 Weeks ○ Greater than 8 week

3f. If No: ○ Scheduled ○ Not Scheduled

4. Did you receive or arrange for contraception?

○ Yes (check all that apply)

☐ prior to delivery ☐ at the time of delivery ☐ after delivery

○ No (check all that apply)

- ☐ Contraceptive Appointment Scheduled
- ☐ Undecided on contraception use
- ☐ Undecided on contractpive method
- ☐ None wanted
- ☐ Using Natural Family Planning
- ☐ Using Abstinence
- ☐ Using Withdrawal
- ☐ No Current Partner

○ Refused

○ Unknown

4a. Contraception Methods Recieved or Arranged For (check all that apply):

Prior to delivery (received or arranged for)	At time of delivery (received)	After delivery (received)
☐ **Primary Method**	☐ **Primary Method**	☐ **Primary Method**
☐ Cervical Cap	☐ Cervical Cap	☐ Cervical Cap
☐ Diaphragm	☐ Diaphragm	☐ Diaphragm
☐ Implant	☐ Implant	☐ Implant
☐ Injectable (Depo-Provera)	☐ Injectable (Depo-Provera)	☐ Injectable (Depo-Provera)
☐ IUD	☐ IUD	☐ IUD
☐ Oral Contraception	☐ Oral Contraception	☐ Oral Contraception
☐ Spermicidal (Jelly, Foam, etc.)	☐ Spermicidal (Jelly, Foam, etc.)	☐ Spermicidal (Jelly, Foam, etc.)
☐ Sterilization	☐ Sterilization	☐ Sterilization
☐ *Tubal Ligation*	☐ *Tubal Ligation*	☐ *Tubal Ligation*
☐ *Vasectomy*	☐ *Vasectomy*	☐ *Vasectomy*
☐ Transdermal Patch	☐ Transdermal Patch	☐ Transdermal Patch
☐ Vaginal Ring	☐ Vaginal Ring	☐ Vaginal Ring
☐ Other	☐ Other	☐ Other
☐ **Condoms**	☐ **Condoms**	☐ **Condoms**
☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
☐ **Emergency Contraception**	☐ **Emergency Contraception**	☐ **Emergency Contraception**

4b. If received, do you have plans for continuing contraceptive supplies and services? ○ Yes ○ No ○ Refused ○ Unknown

4c. If no, was a referral made to obatain contraceptive supplies? ○ Yes ○ No ○ Refused ○ Unknown

5. Are you taking a supplement that contains folic acid? ○ Yes ○ No ○ Refused ○ Unknown

6. Are you breastfeeding? ○ Yes ○ No ○ Unknown ○ Not Applicable

6a. If yes, number of babies from current pregnancy you are breastfeeding? ○ 1 ○ 2 ○ 3 ○ 4 or more ○ Not Applicable

6b. If no, did you ever breastfeed? ○ Yes ○ No ○ Unknown ○ Not Applicable

6c. How long breastfeeding? ○ **Still breastfeeding** *or specify:* _____*Day(s)* _____*Week(s)* _____*Month(s)*

6d. Did you receive breastfeeding support? ○ Yes ○ No

Section III - Concerns

7. Have you had problems with depression or received conseling or medications for mental health concerns? ○ Yes ○ No ○ Refused ○ Unknown

7a. Since your pregnancy ended, have you had little interest in doing things? ○ Yes ○ No ○ Refused ○ Unknown

7b. Since your pregnancy ended, have you been bothered by feeling down, depressed, or hopeless? ○ Yes ○ No ○ Refused ○ Unknown

7c. How do you rate your current stress level? ○ High ○ Medium ○ Low

7d. Depression screening using a standardized screening tool in addition to questions asked previously on this postpartum questionaire? ○ Yes ○ No ○ Refused

7e. If yes, depression screening tool used:

- ○ CDI-s (Adolescent) Score: ______
- ○ CES-D Score: ______
- ○ Edinburgh Depression Scale Score: ______
- ○ PDSS - 35 item Score: ______
- ○ Other Score: ______

7f. Depression screening score indicates risk for depression ○ Yes ○ No

7g. If indicated, referral made for depression risk? ○ Yes ○ No ○ Referral Declined ○ Already Receiving Services

8. Since your pregnancy has ended, have you smoked cigarettes? ○ Yes ○ No ○ Refused ○ Unknown

8a. If yes, average number of cigarettes smoked per day: ______

8b. If indicated, information on smoking cessation/smoking programs or resources provided? ○ Yes ○ No ○ Refused ○ Already Receiving Services

8c. Does anyone in your household smoke ○ Yes ○ No ○ Refused ○ Unknown

9. Since your pregnancy has ended, have you used alcohol? ○ Yes ○ No ○ Refused ○ Unknown

9a. If yes, average number of drinks per week: ______

9b. If indicated, referral made for alcohol use? ○ Yes ○ No ○ Referral Declined ○ Already Receiving Services

10. Since your pregnancy has ended, have you used street drugs? ○ Yes ○ No ○ Refused ○ Unknown

10a. If yes, type of drugs used (check all that apply):

☐ Marijuana ☐ Cocaine ☐ Methadone ☐ Heroin ☐ Other substance abuse ☐ Refused

10b. If yes, average number of times used per week: ______

10c. If yes, how many times per day did you usually use it? ______

10d. If indicated, referral made for street drug use? ○ Yes ○ No ○ Referral Declined ○ Already Receiving Services

11. Since your pregnancy has ended, have you been physically, sexually, emotionally, or verbally abused by your partner or someone close to you? ○ Yes ○ No ○ Refused ○ Unknown

11a. If indicated, referral made for domestic violence? ○ Yes ○ No ○ Referral Declined ○ Already Receiving Services

Section IV - RISK FACTORS

Identified risk factors:

Clark County Health Department

517 Court St., Room 105 * Neillsville, WI 54456-1972 * (715)743-5105 * Toll Free 1-877-743-5105 * Fax (715)743-5115

http://www.co.clark.wi.us/

Postpartum Care Plan

Nursing Dx: ____________________
Interventions: ____________________
____
____
Goals: ____________________
____
Goals Achieved Date: ____________ R.N. Initials: ______

Nursing Dx: ____________________
Interventions: ____________________
____
____
Goals: ____________________
____
Goals Achieved Date: ____________ R.N. Initials: ______

Nursing Dx: ____________________
Interventions: ____________________
____
____
Goals: ____________________
____
Goals Achieved Date: ____________ R.N. Initials: ______

Nursing Dx: ____________________
Interventions: ____________________
____
____
Goals: ____________________
____
Goals Achieved Date: ____________ R.N. Initials: ______

CLARK COUNTY HEALTH DEPARTMENT
PNCC MONTHLY TIME LOG –ONGOING MONITORING & SERVICE COORDINATION

Client (last, first, MI):	**DOB:**	**Month:**	**Year:**
Address:	**Case Manager Name:**		
Agency: Clark County Health Department MA ID Number:	Title: RN-Clark County Public Health Nurse		

Description Codes (***to be used in the second column below***)

RF: Recipient Contact=Face-to-Face Consultation
CF: Collateral Contact=Face-to-Face
S: Staffing
RT: Recipient Contact= Telephone
CT: Collateral Contact= Telephone
R: Record

Place of Service Codes:
03-School
11- Office
12-Home

DATE	CODE	PLACE OF SERVICE	SERVICE CODE	HOURS	MINUTES	UNITS	PROCEDURE CODE	COST BILLED AMOUNT	DOCUMENTATION OF ACTIVITIES

CLARK COUNTY HEALTH DEPARTMENT
PNCC MONTHLY TIME LOG –ONGOING MONITORING & SERVICE COORDINATION

Note: **Prenatal care coordination services are limited to $887.46 per member, per pregnancy.**

PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	REQUIRED MODIFIER	MAXIMUM ALLOWABLE FEE
H1000	Prenatal Care, At-Risk Assessment 1st Prenatal Visit Only		$40.40 (1 Unit Maximum)
H1002	Prenatal Care, At-Risk Enhanced Service; Care Coordination	**U2** Initial Care Plan Development	$48.79 (1 Unit Maximum)
H1002	Prenatal Care, At-Risk Enhanced Service; Care Coordination		$8.28; Each 15 Minutes (1 Unit=15 Minutes)
H1003	Prenatal Care, At-Risk Enhanced Service; Education		$12.63; Each 15 Minutes (1 Unit=15 Minutes)
H1003	Prenatal Care, At-Risk Enhanced Service; Education	**TT** Individualized service provided to more than one patient in same setting (Group Setting)	$12.53; Each 15 Minutes (1 Unit=15 Minutes)
H1004	Prenatal Care, At-Risk Enhanced Service; Home Visit		$10.81; Each 15 Minutes (1 Unit=15 Minutes)
	*Subsequent Pregnancy	**U1**	

- *Use modifier U1 with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. When submitting claims for the second risk assessment, the modifier representing the risk assessment score must also be indicated.
- Submit billing form to program assistant on the last day of each month; make a copy of billing sheet and keep one in the client's chart.
- When submitting claims for development of an initial care plan (H1002-U2); bill for a quantity of 1 unit.
- When submitting claims for the initial assessment, use code H1000; bill for a quantity of 1 unit.
- One unit of service is = to 15 minutes (You CANNOT bill for travel time)
- Physical assessments and their documentation may be completed, but the time for physical assessments and the documentation are not billable PNCC services (code "743" on billing sheet = Not a billable service)
- When billing for chart prep and charting/documentation, it has to match date of service to client.
- You may bill for phone calls, emails and texts using H1002-care coordination. If the client does not answer your phone call you cannot bill for time spent calling or time spent charting. If a home visit is made and the client is not home, you cannot bill for the visit or charting time. If emailing and texting, you must have confirmation of receipt that the message was received by client, meaning you must print the email or text and keep a copy in the client's chart.
- Updates to the assessment or care plan may be billed using procedure code H1002. If updates occur in the home, use procedure code H1004.
- When billing for care coordination (H1002) group together units for the date of service. For example in July, 15 minutes or 1 unit gathering client's chart materials and 30 minutes or 2 units charting = 3 units total under H1002. Describe details either in client's chart in the progress note documenting activities, or describe on the billing log sheet under "documentation of activities."
- At a minimum, one postpartum follow up visit is required; additional visits, phone calls, care coordination can be billed up to 60 days after the birth of the infant for services provided.
  - If clients are illegal citizens, their Badger care coverage ends the last day of the month in which they delivered. Services provided after this date are not reimbursable.

1st visit: Use code H1000-At risk assessment | H1002 charting/documentation | H1004 for depression screening (if in home); if not in home use H1002 | H1002 for 1st breath program (use H1004 instead of H1002 if in the home.) You may bill for Health Teaching (H1003) on the first visit ONLY if you have documented that the Prenatal At-risk Health Assessment has been completed, the care plan has been created and that the client verbally agrees to care plan and will sign hard copy at the next visit. (Documentation MUST follow the order of billable events).
2nd visit: Use code H1002-U2 for care plan development | H1003 for health teaching based on their care plan | H1004 for depression screening and ongoing monitoring (if in home); if not in home use H1002 | H1002 for charting/documentation, chart prep, and gathering educational materials.

- In-between visits: Use H1002-care coordination if calling client to set up visit, prepping chart, contacting doctor, WIC, etc.

Subsequent visits: Use H1003 for health teaching based on their care plan (Health teaching is reimbursed at a higher rate because it must be done by a healthcare professional, i.e. RN or Dietician) | H1004 for depression screening and ongoing monitoring (if in home); if not in home use H1002 | H1002 charting/documentation, chart prep, and gathering educational materials.

Clark County Health Department

517 Court St., Room 105 * Neillsville, WI 54456-1972 * (715)743-5105 * Toll Free 1-877-743-5105 * Fax (715)743-5115

http://www.co.clark.wi.us/

PNCC Evaluation

Dear PNCC client,
I am pleased the Clark County Health Department has been involved in home visits with you and/or your family. At the Health Department we strive to provide the best possible services to our clients. We have created a short questionnaire for you to complete to offer us feedback. We would like to know what we are doing well and what you think we should change.

1. Who was your nurse? ____________________

2. Did you find the visits with the Public Health Nurses helpful? Yes | No

3. What did you like most about the visits with the nurse?

   ____
   ____
   ____

4. Did you read the educational materials that the nurse gave you? Yes | No

5. What could the nurse do to improve the home visits to make them more beneficial for you?

   ____
   ____
   ____

6. Were there any services you wanted that we did not offer?

   ____
   ____
   ____

We have provided a self addressed stamped envelope for you to return this form in. The questionnaire is intended to be anonymous. However, if you have a concern and would like to speak with the Health Department directly please call us at (715) 743-5105 or toll free at 1-877-743-5105.

DATE	PROGRESS NOTES

DATE	PROGRESS NOTES