

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Services: \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Interpreter Name: \_\_\_\_\_

**Nursing Intake**

Age: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_

G: \_\_\_\_\_ P: \_\_\_\_\_ Ab: \_\_\_\_\_ EDC: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

BP: \_\_\_\_\_ Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration \_\_\_\_\_

Allergies: \_\_\_\_\_ Hospital for Delivery: \_\_\_\_\_

**Provider Information**

PCP: \_\_\_\_\_ Family Supportive:  Yes  No

PCP notified:  Yes  No

**Required Documentation** (check when completed)

- Risk factors updated
- Lab results updated
- Physical exam updated if necessary
- AFP ordered
- OB Notification form faxed (if not done previously)

**Social Support**

- Support System:  Yes  No Who: \_\_\_\_\_
- Living arrangements:  Apt.  Home  Hotel  Other
- Baby's father involved/supportive:  Yes  No
- Exposed to violence/abuse:  Yes  No
- ETOH  Drugs  Smoking - How much: \_\_\_\_\_
- Transportation:  Yes  No Working:  Yes  No

**Nutrition**

- Plan on breastfeeding  Plan on bottle feeding
- How many meals per day? \_\_\_\_\_ Does she have money for food?  Yes  No
- Document changes from initial assessment: \_\_\_\_\_

**Psychosocial** (document changes in area of concern from social support section, depression, and feelings about pregnancy):

**Individual Care Plan** (update risk factor assessments, interventions, and outcomes since initial assessments):

**Stop Smoking**

- Advise smoker to quit  Discuss smoking cessation medication  Discuss smoking cessation strategies

**Referrals**

- Pediatrician name: \_\_\_\_\_
- Domestic violence program  Infant car seat program  Renew prenatal vitamins/folic acid
- Housing/emergency shelter  Gestational diabetes education  Drug abuse program

**Health Education**

- Given health education material on :  Obesity, eating disorders, diets  Risk: abuse, drug use, sexual education  Breast self-exam, breastfeeding, formula feeding

**Failed Appointments in First Trimester**

1. Date: \_\_\_\_\_  Card sent/call 2. Date: \_\_\_\_\_  Card sent/call 3. Date: \_\_\_\_\_  Card sent/call

Next trimester reassessment date due on: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_