

Phalcon Label	
Name: _____	CHR#: _____
SSN: _____	Race: _____ DOB: _____
Med#: _____	Sex: _____ Date: _____
Address: _____	Phone: _____

Maternity Psychosocial Risk Assessment Steps Ahead Maternity Care Program

<p>1. Personal Profile:</p> <input type="checkbox"/> 16 years or less*** <input type="checkbox"/> School dropout <input type="checkbox"/> Homeless*** <input type="checkbox"/> Handicapped <input type="checkbox"/> Language barrier <input type="checkbox"/> Non-Compliant with Medical Care***	<p>8. Maternal Losses:</p> <input type="checkbox"/> Previous fetal loss <input type="checkbox"/> Previous neonatal loss <input type="checkbox"/> Death of infant <1 year <input type="checkbox"/> Other: _____ _____ _____
<p>2. Family Factors:</p> <input type="checkbox"/> Lack of support for father of child <input type="checkbox"/> Lack of support from family <input type="checkbox"/> No support system***	<p>9. Family Planning:</p> <input type="checkbox"/> Unreliable birth control method** <input type="checkbox"/> Requested sterilization after delivery**
<p>3. Emotional/Mental Health:</p> <input type="checkbox"/> Negative feelings about pregnancy* <input type="checkbox"/> Depression* <input type="checkbox"/> Fears regarding pregnancy* <input type="checkbox"/> Mental health incapacity*** <input type="checkbox"/> History of psychiatric/emotional*** <input type="checkbox"/> Problems	<p>10. Family Violence:</p> <input type="checkbox"/> Suspected domestic violence*** <input type="checkbox"/> Suspected rape/incest*** <input type="checkbox"/> Pt sexually abused as child*
<p>4. Recent Stressful Life Events:</p> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death of someone close <input type="checkbox"/> Loss of job/income	<p>11. Environmental Factors:</p> <input type="checkbox"/> Utilities disconnected* <input type="checkbox"/> Substandard housing* <input type="checkbox"/> Transportation problems* <input type="checkbox"/> Other: _____
<p>5. Motherhood:</p> <input type="checkbox"/> Lack of positive role model <input type="checkbox"/> Negative/Uncertain feelings toward motherhood <input type="checkbox"/> Considering adoption of baby* <input type="checkbox"/> Inability to provide infant care* <input type="checkbox"/> Considering alternatives to pregnancy	<p>12. Self-reported Medical Conditions:</p> <input type="checkbox"/> HIV/AIDS*** <input type="checkbox"/> Diabetes*** <input type="checkbox"/> Syphilis <input type="checkbox"/> Anemia <input type="checkbox"/> Seizures <input type="checkbox"/> Hypertension <input type="checkbox"/> Genetic condition: _____
<p>6. Alcohol/Drug Abuse:</p> <input type="checkbox"/> History of alcohol/drug abuse*** <input type="checkbox"/> Drugs currently using***: _____	<p>13. Medicaid Eligibility:</p> <input type="checkbox"/> Requires assistance with paperwork <input type="checkbox"/> Failed to submit documentation <input type="checkbox"/> All paperwork submitted: waiting for approval
<p>7. Other Children:</p> <input type="checkbox"/> Children removed from home because of abuse/neglect*	

*Requires referral(s) or additional face-to-face encounters in the office, clinic, or patient's home.

**Two Visits

***Three Visits

Always use professional judgement. Any of these risk factors could justify additional face-to-face encounters in the office, clinic, or patient's home.