

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)		
	Month	Day
		Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		

MATERNAL HEALTH EDUCATION FORM

Codes for Types of Education:

- | | |
|---|---------------------------------------|
| I Individual counseling | G Group or class |
| P Packet of Information (standard) | L Literature given |
| V Video shown | H Health Mom/Healthy Baby Book |
| R Review of material | N See Progress Notes |

Pregnancy Counseling/Enrollment	Check	2 nd Trimester	Check
All below reviewed with patient at initial visit Date/Initial →		All below reviewed with patient in the 2nd Trimester Date/Initial →	
• Medicaid (how to apply)		• Signs and Symptoms to Report: bleeding, leaking fluid, rupture of membranes, preterm labor, decreased fetal movement	
• Ed on Emergency Medicaid (if applicable)		• After-hours Emergency Line (who to call)	
• Lab Studies Anticipated		• Risks and Benefits of Breastfeeding and Infant Formula Feeding	
• Expected Course of Prenatal Care		• Child Birth Education (Lamaze)	
• Anticipated Schedule of Visits		• Child Care/Parenting Classes	
• Scope of Care Provided		• Neonate's Provider	
• Insurance & Cost (prenatal & delivery)		• Circumcision (if applicable)	
• After-hours Emergency Line (who to call)		• Birth Control Method (start assessing and ed)	
• Physician/Provider Coverage		• Preterm Labor	
• Prenatal Vitamins		• Pre-Eclampsia	
• OTC and Rx Medicines		• Depression (prenatal and postpartum)	
• Pregnancy Care Management		• Dental Care	
• WIC		• Nausea and Vomiting (Persistent)	
• Office Policies		• Other:	
• Nausea & Vomiting During Pregnancy			
• Caution about ETOH/Tobacco use/**ENDS			
• Other:			
1st Trimester	Check	3rd Trimester and Postpartum Period	Check
All below reviewed with patient in the 1st Trimester Date/Initial →		All below reviewed with patient in the 3rd Trimester/Postpartum Date/Initial →	
• After-hours Emergency Line (who to call)		• After-hours Emergency Line (who to call)	
• Interpersonal Violence		• Back-to-sleep/Safe Sleep	
• Environmental Exposure/Sauna & Hot Tubs/Lead/ETS*/ENDS**		• Shaken Baby Syndrome	
• Nausea/Vomiting During Pregnancy		• Decide on neonate's provider	
• Danger Signs to Report: bleeding like a period, severe abdominal pain, fever (signs/symptoms of SAB)		• Signs and Symptoms to Report: bleeding, leaking fluid, rupture of membranes, preterm labor, decreased fetal movement	
• Balanced Nutrition including ideal calorie intake, weight gain and foods to avoid. Include vitamins and mineral toxicity.		• Planning for hospital discharge and child care, choosing the car seat information and immunization info.	
• Travel Safety and Seatbelt Instruction		• Depression (revisit-postpartum)	
• Daily Activity/Exercise Safety Including Warning Signs		• Cost to the patient for delivery, e.g., insurance plan participation	
• Food Safety (Mercury/Listeria)		• Postpartum Home Visit/Newborn Home Visit	
• Caution about ETOH/Tobacco use/**ENDS		• Labor Preparation — what to do when labor begins	
• Prevention of STIs/HIV in Pregnancy		• Preparing for Birth & After	
• Assess previous prescribed drugs and caution about substance use including illegal, over-the-counter drugs and home remedies.		• L&D: signs; who to call; comfort measures & pain relief; birth coach and progression of labor.	
• HIV Counseling and Testing. Explain N.C. HIV and Pregnancy Testing Laws.		Plans to Breastfeed <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Smoking Cessation Counseling — (Use the 5 A's)		FP Education & Contraceptive Choice _____	
• Other:		• Postpartum Warning Signs and Symptoms	
		• Other:	

*ETS - Environmental Tobacco Smoke

**ENDS - Electronic Nicotine Delivery Systems

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)		
	Month	Day
		Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		

SIGNATURE RECORD

Signature	Initials	Signature	Initials

Instructions for the Maternal Health Education Sheet

Purpose: To document all education provided through the Health Department in the course of prenatal care.

- Instructions: 1. Any care provider or staff who educates client should document on this form.
2. Next to appropriate topic, enter code for type of education provided
I Individual counseling **G** Group or class **P** Packet of Information (standard)
L Literature given **V** Video shown **H** Healthy Mom, Healthy Baby Book
R Review of material **N** See Progress Notes (More than one code may be used, as needed.)

3. Date and initial next to code entered.

CATEGORY/TOPICS	Date/Type/Initial
1 st Trimester	
HIV Counseling and Testing	11/11/09/ I / JR

4. Utilization of the Healthy Mom, Healthy Baby Book is encouraged.
If you write on a progress note use code N to indicate a progress note was written.

Example:

CATEGORY/TOPICS	Date/Type/Initials
2 nd Trimester	
Preterm Labor	12/12/09/ H, N/ MP

Sign and initial signature record above. **(Required only once per provider.)**

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
<http://whb.ncpublichealth.com/provPart/forms.htm>