PRENATAL WELLNESS ASSESSMENT

PURPOSE

To build relationship with pregnant moms and families through engaging conversations while gathering information about their confidential health history. Staff must make sure that pregnant women enrolled in Early Head Start have access to ongoing prenatal health and dental care as well as other family resources per Head Start Performance Standard 1302.80-1302.82. Information gathered during these conversations will support family goals, identify needs for support, and inform planning of upcoming Home Visits.

Medical/Dental Insurance/Homes

- Determine whether the pregnant woman has medication and dental coverages and is receiving regular prenatal and dental care.

Pregnancy Services

- Determine current services and assess resources needed.
- Perinatal Mental Health Referrals

Nutrition

- Determine family's plan to breast of formal feed. Assess the need for more information.
- Review maternal nutrition status. Offer Referral to internal Nutritionist.

Risk assessment

- Identify health concerns and other factors that may affect the pregnancy and birth and offer resources as needed.
- Consult with supervisor, Public Health Nurse Consultant, program managers with questions or concerns.

Pregnancy Goals

- Identify family's preparation, strengths and expectations for upcoming birth.

PROCEDURE

Gather the following information during initial home visits and utilize it to plan for upcoming supports, home visits, and family interactions. This must be completed **within 30 days** of First Day of Service.

Name: _____ **Due Date:** _____

Medical coverage for pregnancy? ☐ Yes ☐ No ***If yes, what type*:** ☐ Medicaid/Provider One ☐ Private Insurance

Are you receiving prenatal care? ☐ Yes ☐ No **Chosen healthcare provider for baby?** ☐ Yes ☐ No

Prenatal Healthcare Provider: _____ **Phone:** _____

Date of 1st prenatal visit: _____ **Date of Last Prenatal Visit:** _____

Date of next prenatal visit: _____ *(if no prenatal care, priority is to connect with care provider)*

Have you been told by your provider that this is a high-risk pregnancy? ☐ Yes ☐ No

If yes, please specify: _____

Are you up to date on your own immunizations? ☐ Yes ☐ No

Do you have questions about your nutrition? ☐ Yes ☐ No

If yes, please specify: _____

Are you taking prenatal vitamins/iron supplements? ☐ Yes ☐ No

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Supports Currently Receiving:	☐ Maternity Support Services (MSS) ☐ Parent Child Assistance Program (PCAP) ☐ Nurse/Family Partnership ☐ Doula/Midwife ☐ WIC/SNAP ☐ Mental Health Counseling ☐ Chemical Dependency Treatment	**Prenatal Resources Provided?**	☐ Yes ☐ No **List:** • •

Do you have dental coverage? ☐ Yes ☐ No **Date of last exam:** _____

Do you currently need dental treatment? ☐ Yes ☐ No **Plan for treatment?** ☐ Yes ☐ No

If yes, when? _____

Dental Provider: _____ *(if no dental provide, priority is to connect with care provider)*

Do you need assistance with clothing, furniture, or equipment for your baby? ☐ Yes ☐ No

If yes, please specify: _____

How do you plan to feed your baby? ☐ Breastfeed ☐ Formula Feed ☐ Unsure

What are you doing for activity? How often? _____

Have you used any of the following during your pregnancy?

Please check all that apply. Talk about frequency of use, if discontinued, if need additional support.

Caffeine: _____

Cigarettes/Tobacco: _____

Over the Counter Medications: _____

Prescription Medications: _____

Alcohol/Marijuana/Other Drugs: _____

Would you like more information on any of the above? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any questions or concerns about this pregnancy or the birth of your baby? ☐ Yes ☐ No

If yes, please specify:

Do you have a history of pregnancy complications that required bed rest or hospitalization? ☐ Yes ☐ No

If yes, please specify:

What steps are you taking to prepare for this baby?

Who is your support system? How are they supporting you?

What are you looking forward to the most about the birth of this baby?