Goodwin
Community Health

Thank you for choosing Goodwin Community Health for your Prenatal Care. Please know that your prenatal needs are at our highest priority and during your time here, we are fully committed to making this the best experience possible for you.

In order to provide accurate prenatal care and complete coordination of your care, please take a moment to read over and sign the authorization for care below.

Authorization for Care – Prenatal Program

Authorization is hereby given to Goodwin Community Health to assign such staff as deemed necessary to render services to me, while I am a patient in the Prenatal Program, in accordance with the program policies of Goodwin Community Health.
Such care may include:

- Treatment prescribed by the Program Medical Staff
- Medical Supervision
- Medication Administration
- Medical Testing
- Drug Screening as deemed necessary by your provider
- Social Services
- Nutritional Services
- Education
- Monitor / check NH State Drug Monitoring System as deemed necessary

Authorization also includes the sharing of medical record information between Physicians, hospital staff at: **(check one)**

☐ Wentworth Douglass Hospital ☐ Frisbie Memorial Hospital

The Visiting Nurse agency, Community Action Program of Strafford County and Maine Families Home Visiting programs for complete coordination of prenatal care consistent with HIPAA guidelines.

In order to improve maternity care services in New Hampshire; the division of Public Health Services is requesting permission to collect some information regarding your pregnancy. All information provided would be kept confidential and used for statistical purposes only.

This consent expires 60 days after delivery.

By signing below, you are stating that you have read and understand the above details about the prenatal program and given the opportunity to have any questions addressed regarding the above.

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Packet Last Updated 04/02/15

Goodwin Community Health

Genetic History- Risk Factor

The following questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. Please answer all of the questions to the best of your ability. All information will be kept confidential.

Please place a check mark ☑ in the box stating either "Yes" "No" or "Unknown" under the appropriate column indicating "Patient" or "Baby's Father." If you have additional information you think we need to know, please write it in the provided "Comments" box.

Patient Name: _____ Date of Birth: _____

History of	Patient			Baby's Father			Comments
	Yes	No	Unknown	Yes	No	Unknown	
Thalassemia							
Neural Tube Defect							
Down's Syndrome							
Tay-Sachs							
Sickle Cell Disease/Trait							
Hemophilia							
Muscular Dystrophy							
Cystic Fibrosis							
Huntington Chorea							
Mental retardation							
Fragile X							
Other Genetic/Chromosomal							
Child w/ other Birth Defect							
Other							

Do you have any additional concerns you would like to address with the provider?

_____

_____

_____

_____

Federal Re-disclosure Statement: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR) prohibit you from making any further disclosures of it without specific written consent from the person to whom it pertains, or as otherwise permitted by such regulations.

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Questionnaire for Evaluation of Behavioral Health

20% of women will have serious symptoms related to depression or anxiety at some time in their lives, pregnancy and postpartum are times when women are more likely to have this kind of trouble.

This questionnaire will help us identify women who may need extra support or services during pregnancy or postpartum. This questionnaire will not be part of your record.

1.) Have you ever had any of the following problems? (circle all that apply)

Premenstrual Disorder

Depression

Postpartum Depression

Anxiety

Substance Abuse

Manic-Depressive Disorder

Difficult Labor or Delivery

2.) Do you have a history of sexual abuse or a sexual assault? _____

3.) Have you been prescribed any of the following medicines? (circle all that apply)

Prozac Zoloft Effexor Pamelor Elavil Valium Ativan Klonapin

Any other medications for behavioral health _____

4.) Have you been in treatment for any of the above problems? (circle one) Yes No

If yes, When? _____ Where? _____

5.) Do you have any pressing concerns or feel you may be suffering from depression? (circle one)

Yes No

If yes, please briefly describe: _____

_____

_____

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Risk Assessment for AIDS and Sexually Transmitted Diseases (STD)

Please review the following statements so we can be helpful in assessing your risks and provide you with the best medical care and information. We are aware these issues are very sensitive, but be assured any information you give will be kept strictly confidential.

You are at risk if any of the following pertain to you directly or if you have had or are having intercourse (vaginal, oral or anal) with a:

- Partner who has or has previous sexual partners
- Gay or bisexual partner
- IV drug user
- Partner with a positive HIV test or with AIDS
- Hemophiliac or partner of a hemophiliac
- Partner with a positive hepatitis or positive TB
- Heavy daily alcohol drinker or drug user
- Partner who has spent time in jail
- Prostitute or partner to a prostitute
- Partner(s) of whom you do not have knowledge of sexual/drug history
- If you have been raped or sexually assaulted

Sexually transmitted diseases/AIDS can affect pregnancy. If you are planning a pregnancy, you may want to be tested for STD's prior to becoming pregnant. Please feel free to ask about the tests available.

Your exam includes routine tests for gonorrhea and/or chlamydia. Both of these bacteria can cause infections with or without symptoms. People may not know they have it, and therefore spread it to others through sexual contact. You may also request a test for syphilis. These infections can be treated, but if left untreated, can cause severe problems such as sterility in men and women.

Goodwin Community Health's recommendation is for everyone to have both tests. There are a number of other STD's that also may not have any symptoms. Some are easily treated while others are not. For this reason it is also our recommendation that you use condoms every time you have intercourse.

The above statements have been reviewed and discussed with me. I have received risk reduction information, and have been made aware that STD and HIV testing is available at Goodwin Community Health.

Patient's signature: _____ Date: _____ STD Pamphlet: _____

I witness the fact that this patient received the above information and said she read and understood it.

Witness signature: _____ Date: _____

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Tuberculosis Risk Assessment Questionnaire

1.) Is there a family history of tuberculosis or is a family member on medication for the disease?

2.) Do you or any household members have an immune deficiency disease like HIV/AIDS or Hodgkin's Lymphoma?

3.) Or chronic diseases like diabetes, or chronic kidney failure?

4.) Or taking chemotherapy?

5.) Or suffering from malnutrition?

6.) Have you, any family members or close contacts recently been in jail, prison, a nursing home, a homeless shelter or homeless?

7.) Are you or any family members immigrants from a foreign country?

8.) Are any family members or close contacts IV drug users?

9.) Is tuberculosis active in your neighborhood?

10.) Have you had a TB test done in the last year?

Patient's signature: _____ Date: _____

Staff signature: _____ Date: _____

Goodwin Community Health

P-SUS Health History

Patient Name: _____ DOB: _____

Since your last menstrual period, have you used any of the following? Please be as accurate as possible.

Medication	Yes or No	Brand of Medication	Last Time Taken
Asprin Type (acetylsalicylic acid)			
Tylenol Type (acetaminophen)			
Motrin Type (ibuprofen)			
Prescribed Narcotics (Morphine, Darvocet, Percocet, Oxycodone)			
Cold, Flu, or Cough Medicine			
Allergy Medicine			
Birth Control (all forms)			
Acne Medication			
Anti-Seizure or Anti-Convulsive			
Sleeping Pills / Tranquilizers			
Diet Pills, Laxatives, or Anti-Diarrheal			
Vitamins			
ANY Other (including prescribed medication)			

If you have any other comments regarding the above questions, please fill out below.

_____

_____

_____

_____

P-SUS Health History continued

Have you **EVER used ANY** of the following, be as accurate as possible. This includes anything used in the past or presently.

Medication / Drug Type	Yes or No	Last time used & How much
Cigarettes / Smokeless Tobacco		
Alcohol		
Sleeping Pills, Barbituates, Tranquilizers (non-Prescription use)		
Marijuana		
Cocaine / Crack		
Amphetamines (non-prescription use)		
Narcotics / Heroin		
PCP		
Inhalants		
LSD, Mushrooms, Hallucinogens		
Bath Salts		
Methadone, Suboxone (street use)		
Other		

Are you now, or have you **EVER** been enrolled in a treatment program for substance abuse use? Please check one of the following:

_____ Currently _____ Previously _____ N/A

If so, please describe treatment below.

_____

_____

_____

_____

_____

_____

Intake Questionnaire

Your name_____ DOB_____

Who is your emergency contact? _____ Phone number_____

What is his / her relationship to you? _____

Do you have any other children? Yes No Do they live with you? Yes No

Please tell us their names and ages _____

_____

Who else lives in the home with you? _____

_____

Who do you expect to be helpful with the baby? _____

_____

Are you close with your immediate family? Yes No

Please explain: _____

_____

What is your highest level of education completed? *(Please circle and fill in if required)*

Last Grade Completed _____ GED #of Years Completed in College_____

What do you do for work? _____

Do you work … Full Time or Part-Time

What have you used for birth control in the past? _____

Do you plan to use birth control after the birth? Yes No

If yes, what method you would like to use? (If known)_____

In the three months before you learned about this pregnancy, how many days a week, on average, did you drink an alcohol beverage? _____

On average, on many drinks did you usually drink when you did drink? _____

When was your last alcohol beverage? _____

In the three months before you learned about this pregnancy, did you use illicit drugs or non-prescribed medication? Yes No

What were you using? _____

When was your last use? _____

Father of the baby _____ DOB_____

Address_____ Phone number _____

How do you describe his race / ethnicity? _____

Does he smoke cigarettes? Yes No

Are there any concerns regarding his alcohol use? Yes No

Please explain _____

_____

Does he use any illicit drugs or non-prescribed medication? Yes No

Please explain _____

_____

How long have you and the father of the baby been in a relationship? _____

Are you still together? Yes No

Do you have, or have you ever had, any concerns about your safety? Yes No

What is his highest level of education <u>completed?</u> *(Please circle and fill in if required)*

Last Grade Completed _____ GED #of Years Completed in College_____

What does he do for work? _____

Does he work … Full Time or Part-Time

Does he have any other children? Yes No Do they live with him? Yes No

Please tell us their names and ages _____

_____

Is his immediate family helpful? Yes No

Please explain: _____

_____

Does he have any mental health issues? Yes No

If yes, what is the diagnosis and treatment? _____

_____

PCDF

Your name _____ DOB_____/_____/_____

Maiden name, if applicable *(the last name you had before marriage)* _____

Father of the baby's name _____ DOB _____/_____/_____

What kind of insurance, if any, do you have or plan to have for this pregnancy? _____

How many people live with you? *Only count yourself, your children, any immediate family (mom, dad, siblings), and your husband, if married. Please do not count your partner if not married*. _____

What is the gross annual income for those counted in the previous question? _____

To the best of your knowledge, what was the first day of your last period? _____/_____/_____

What type of birth control, if any, were you using at the time of conception? _____

Please tell us how you describe your Race. (Please circle all that apply)

White	Filipino	Native Hawaiian
Black / African America	Japanese	Guamanian or Chomorro
American Indian / Alaska Native	Korean	Samoan
Asian Indian	Vietnamese	Other Pacific Islander _____
Chinese	Other Asian _____	_____
		Other_____

Do you have any Hispanic background? Yes No
If yes, please tell us what country your family comes from. (Please circle all that apply)

Mexico Puerto Rico Cuba

Other Hispanic country (Please tell us which country) _____

Do you smoke cigarettes? Yes No

If you answered yes, how many cigarettes are you currently smoking every day? _____
How many did you smoke before you learned of your pregnancy? _____
If you used to smoke, when did you quit? _____

Are you ever in the same room with a smoker? Yes No

If you answered yes, on average, **how many hours** a day, are in you the same room with someone who is smoking? _____

Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Please choose the **ONE** that best describes how you felt.

_____ I wanted to be pregnant sooner
_____ I wanted to be pregnant later
_____ I wanted to be pregnant then
_____ I did not want to be pregnant then or at any time

First PN Visit _____/_____/_____ *EDC* _____/_____/_____