NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Prenatal Plus Program

Prenatal Plus Intake Assessment

To be completed by the patient and PPP care coordinator.

Patient Name:		
Date of Birth:	EDD:	Date of Enrollment:
Weeks Gestation at Enrollment:	Medicaid ID:	

Care Coordinator Name:	Phone Number:
Clinic Name:	Fax Number:
Name of Clinician:	

Section 1: Reason(s) for Enrollment

Patient is at risk of poor maternal and/or infant health outcome(s) due to at least one (1) of the following (check all that apply):

- ☐ History of previous low birth weight infant
- ☐ Age 18 or younger at time of conception
- ☐ Age 35 or greater at time of conception
- ☐ Recent or current alcohol use
- ☐ Recent or current illicit drug use
- ☐ Recent or current smoker
- ☐ Pre-pregnancy BMI less than 18.5 kg/m2
- ☐ Pre-pregnancy BMI greater than or equal to 30 kg/m2
- ☐ Recent delivery (12 months prior)
- ☐ Inadequate prenatal weight gain
- ☐ Education level less than appropriate for age
- ☐ Single parent
- ☐ Cognitive or developmental disability
- ☐ Member does not desire the pregnancy or has unresolved feelings regarding pregnancy
- ☐ Experienced a pregnancy loss
- ☐ History of or current mental health disorder, including depression
- ☐ History of or current domestic violence
- ☐ History of abuse in childhood
- ☐ Incarcerated within the past year, currently on probation or received a felony conviction within past 2-5 years
- ☐ Has been homeless within the past 12 months
- ☐ Moved to the U.S. within past 6 months as a refugee or political asylee
- ☐ English spoken as a 2nd language or lives in a household where English is not primary language
- ☐ Member lacks social supports
- ☐ In the last 12 months, member had a death of someone very close to them
- ☐ In the last 12 months, their partner went to jail
- ☐ In the last 12 months, someone very close to them has had drug or alcohol problems
- ☐ In the last 12 months, they are/were separated or divorced from their partner
- ☐ In the last 12 months, their partner lost his/her job
- ☐ In the last 12 months, the member lost their job
- ☐ In the last 12 months, they argued with their partner more than usual
- ☐ In the last 12 months, partner said he/she didn't want the member to be pregnant
- ☐ In the last 12 months, the member had a lot of bills they couldn't pay
- ☐ In the last 12 months, the member was in a physical fight
- ☐ Clinician determines that member is at risk of having a negative maternal or infant health outcome

Section 2: Nutrition and Exercise

1. During this pregnancy have you had daily or severe nausea or vomiting?
   - ☐ Yes
   - ☐ No
2. Do you have any problems that make eating/drinking difficult?
   - ☐ Yes
   - ☐ No

   If yes, what?

3. If you have been pregnant before, how much weight did you gain with each pregnancy?

4. Do you exercise?
   - ☐ Yes
   - ☐ No

   If yes, what do you do for exercise and how often?

5. Are you on a special diet now such as: low-calorie, low-salt, low-carb, diabetic?
   - ☐ Yes
   - ☐ No

   If yes, why?

6. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?
   - ☐ Yes
   - ☐ No

   If yes, what did you crave/eat, how much and how often?

7. Have you ever run out of food?
   - ☐ Yes
   - ☐ No
8. Do you feel you have enough food now?
   - ☐ Yes
   - ☐ No
9. Have you ever thought or been told you had anorexia or bulimia?
   - ☐ Yes
   - ☐ No

Section 3: Sources of Income

1. Are you currently working?
   - ☐ Yes
   - ☐ No
2. Do you receive/want to receive any of the following:
   - ☐ Women, Infants, and Children (WIC)
   - ☐ Supplemental Nutrition Assistance Program (SNAP/Food Stamps)
   - ☐ Aid to Dependent Children (ADC) / Temporary Assistance for Needy Families
   - ☐ Low Income Home Energy Assistance Program (LIHEAP)
   - ☐ Child Care Subsidy

Section 4: Educational/Vocational Goals

1. Are you currently in school?
   - ☐ Yes
   - ☐ No

   If no, what is the last grade that you finished?

2. Has anyone told you that you have a learning, cognitive, or developmental disability?
   - ☐ Yes
   - ☐ No

3. If you answered yes to question #2, would you like help finding resources specific to the disability or disabilities?
   - ☐ Yes
   - ☐ No
   - ☐ N/A

4. Do you plan to work or go to school after the baby is born?
   - ☐ Yes
   - ☐ No
   - ☐ N/A

Section 5: Social Supports

Who are support people in your life? (i.e. partner, parents, church, doula, friends, coworkers, other relatives, etc)

Section 6: Living Arrangements and Transportation

1. What forms of transportation do you use? _____
2. Where do you live?
   - ☐ Apartment
   - ☐ House
   - ☐ Shelter
   - ☐ No housing
   - ☐ Other _____
3. Does anyone else live with you in your home?
   - ☐ Yes
   - ☐ No

   If yes, please provide the following information:

Name	Age	Relationship to You

4. Do you have any other children who do not live with you?
   - ☐ Yes
   - ☐ No

   If yes, where do they live?

5. How many times have you moved in the past 12 months?

6. Do you think your current housing situation is adequate and safe?
- ☐ Yes
- ☐ No

Section 7: Substance Use Screening Tool

Do you...	Before pregnancy	Since getting pregnant
1. Smoke cigarettes? If yes, how many a day?	☐ Yes ☐ No	☐ Yes ☐ No
2. Use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No
3. Use e-cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No

4. Does anyone in your home smoke? Or are you around people who are smoking?
- ☐ Yes
- ☐ No

5. If you are currently smoking or have recently used tobacco, please check the best answer below:
- ☐ I do not want to quit
- ☐ I have thought about quitting but I am not ready yet
- ☐ I want to quit soon
- ☐ I recently quit smoking
- ☐ I quit smoking but I have started again
- ☐ I quit smoking and I will not start again
- ☐ N/A

6. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?

For the following questions, a drink equals one 12-ounce beer, one 4-ounce glass of wine, or one 1-ounce shot of hard liquor.

7. When was your last drink?
- ☐ This week
- ☐ Last week
- ☐ Last month
- ☐ Months ago
- ☐ Never

8. How many drinks does it take for you to feel the effects of alcohol?

9. Have you ever been treated for problems with alcohol?
- ☐ Yes
- ☐ No

If yes, when? _____

10. Would you like help to quit drinking alcohol while you are pregnant and/or breastfeeding?
- ☐ Yes
- ☐ No

11. How often do you use cannabis?
- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

12. If yes, when was the last time you used cannabis?
- ☐ This week
- ☐ Last week
- ☐ Last month
- ☐ Months ago
- ☐ Never

13. Have you ever thought about cutting down, or stopping, your use of cannabis?
- ☐ Never
- ☐ Yes, but not in the past six months
- ☐ Yes, during the past six months
- ☐ N/A

14. Would you like support in decreasing your substance use (including cannabis) while pregnant and/or postpartum?
- ☐ Yes
- ☐ No

15. Have you ever been treated for problems with illicit drugs/substances?
- ☐ Yes
- ☐ No

If yes, when? _____

16. Does anyone in your home have a problem with drugs or alcohol?
- ☐ Yes
- ☐ No

Unintentional opioid overdose is a leading cause of maternal mortality. Would you accept a prescription for Naloxone to keep in your medicine cabinet in case you or someone you know needs to reverse an overdose?
- ☐ Yes
- ☐ No

Section 8: Psychosocial

1. When you first learned you were pregnant, how did you feel about it? (Check the best answer)
- ☐ I wanted to be pregnant sooner
- ☐ I wanted to be pregnant then
- ☐ I wanted to be pregnant later
- ☐ I did not want to be pregnant then or at any time in the future

Clarify response here:

2. What causes you to feel stressed?

3. When you are upset, do you (check all that apply):
- ☐ Cry
- ☐ Count your blessings, hope, pray, think “I can make it”
- ☐ Talk to someone
- ☐ Rock
- ☐ Ignore it
- ☐ Try to keep busy (watch TV, listen to music, read, shop)
- ☐ Practice relaxing
- ☐ Use drugs
- ☐ Drink alcohol
- ☐ Eat
- ☐ Try to figure out what’s going on
- ☐ Smoke
- ☐ Go for a walk
- ☐ Sleep
- ☐ Daydream
- ☐ Lose your temper
- ☐ Party
- ☐ Think of the future
- ☐ Take it out on someone else
- ☐ Other _____

Clarify response here:

4. What do you feel is the best thing about yourself? What are your strengths? What would people who know you say they like about you?

5. Have you ever been diagnosed with any of the following (check all that apply):

- ☐ Depression
- ☐ Anxiety
- ☐ Postpartum depression or the “baby blues”
- ☐ Bi-polar disorder
- ☐ Schizophrenia
- ☐ Other

Clarify response here:

Did you see a counselor for any of the above? ☐ Yes ☐ No
If so, when?

For how long?

Did you take medicine for any of the above? ☐ Yes ☐ No
If yes, what kind?

When did you last take it?

Who prescribed it?

Were you hospitalized for any of the above? ☐ Yes ☐ No
If so, when?

For how long?

6. Do you have concerns about postpartum depression or the “baby blues”? ☐ Yes ☐ No
Clarify response here:

7. Do you have any thoughts or plans about hurting yourself? ☐ Yes ☐ No
Clarify response here:

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

8. In the past, have you ever tried to hurt yourself? ☐ Yes ☐ No
If yes, how and when?

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

9. Do you have any thoughts or plans about hurting anyone else? ☐ Yes ☐ No
Clarify response here:

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

10. Have you ever repeatedly been put down, or hurt emotionally? ☐ Yes ☐ No
If yes, when?

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

11. Are you now, or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? ☐ Yes ☐ No
If yes, when?

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

12. Are you now, or have you ever been uncomfortably touched or forced into sexual contact? ☐ Yes ☐ No
If yes, when?

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

13. Does anyone in your life make you feel humiliated, threatened, or afraid? ☐ Yes ☐ No
If yes, who?

(If yes, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

14. How safe do you feel in your current living situation?
- ☐ Very safe
- ☐ Somewhat safe
- ☐ Very unsafe
- ☐ Not really sure how safe

Clarify response here:

(If patient states unsafe, patient must immediately be connected to the clinician, nurse or MCO case manager nurse)

15. Have you ever been involved with the legal system (juvenile court, probation, jail, parole)? ☐ Yes ☐ No
If yes, when?

16. Have you ever been in the foster care system? ☐ Yes ☐ No
If yes, when?

Patient signature:_____ Date signed:_____

Care coordinator signature:_____ Date completed:_____

Clinician signature:_____ Date reviewed:_____

Resources

To be completed by the patient and PPP care coordinator. The care coordinator (CC) will date and initial when information is provided on topics chosen by the patient.

The Prenatal Plus Program has helpful information for you during your pregnancy. Please check any topics you would like more information about:

	Topic	Date	CC Initials
	Nutrition		
	Exercise		
	Assistance getting food		
	WIC - Women, Infants, and Children program		
	Work options		
	Resources for clothing, baby supplies, etc		
	Financial help		
	School/GED resources		
	Housing/shelter		
	Heat resources for your home		
	Counseling		
	Getting along with your partner or family		
	How to prevent a low birthweight or premature baby		
	Quitting smoking		
	Secondhand smoke		
	Reducing/quitting drugs or alcohol		
	Coping with changes during pregnancy		
	Growth and development of your baby		
	Choosing a doctor for your baby		
	Labor and delivery		
	Childbirth classes		
	Breastfeeding and other infant feeding options		
	Caring for yourself and your baby after you get home		
	Postpartum depression or anxiety		
	Parenting		
	Daycare		
	Birth control methods		
	Other _____		

Edinburgh Postnatal Depression Scale (EPDS)

To be completed by the patient.

Patient Name:	Date of Birth:	Today's Date:

Since you are pregnant, we want to know how you feel. Please place a check mark on the blank by the answer that comes closest to how you have felt IN THE PAST 7 DAYS.

1. I have been able to laugh and see the funny side of things:
   - As much as I always could ____ (0)
   - Not quite so much now ____ (1)
   - Definitely not so much now ____ (2)
   - Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   - As much as I ever did ____ (0)
   - Rather less than I used to ____ (1)
   - Definitely less than I used to ____ (2)
   - Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time ____ (3)
   - Yes, some of the time ____ (2)
   - Not very often ____ (1)
   - No, never ____ (0)

4. I have been anxious or worried for no good reason:
   - No, not at all ____ (0)
   - Hardly ever ____ (1)
   - Yes, sometimes ____ (2)
   - Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   - Yes, quite a lot ____ (3)
   - Yes, sometimes ____ (2)
   - No, not much ____ (1)
   - No, not at all ____ (0)

6. Things have been getting to me:
   - Yes, most of the time I haven't been able to cope at all ____ (3)
   - Yes, sometimes I haven't been coping as well as usual ____ (2)
   - No, most of the time I have coped quite well ____ (1)
   - No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time ____ (3)
   - Yes, sometimes ____ (2)
   - No, not very often ____ (1)
   - No, not at all ____ (0)

8. I have felt sad or miserable:
   - Yes, most of the time ____ (3)
   - Yes, quite often ____ (2)
   - Not very often ____ (1)
   - No, not at all ____ (0)

9. I have been so unhappy that I have been crying:

Yes, most of the time	____ (3)
Yes, quite often	____ (2)
Only occasionally	____ (1)
No, never	____ (0)

10. The thought of harming myself has occurred to me:

Yes, quite often	____ (3)
Sometimes	____ (2)
Hardly ever	____ (1)
Never	____ (0)

TOTAL SCORE:_____

The total score is found by adding together the scores for each of the 10 items. Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan.

Care coordinator signature:_____ Date reviewed:_____

Clinician signature:_____ Date reviewed:_____