Prenatal Assessment Form (Staywell Only)

Patient Info

First Name: _____

Last Name: _____

DOB: _____

Provider: _____

DOS: _____

HEDIS Timeliness of Prenatal Care

The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization (Please fill in any that are applicable) Suggested HEDIS Codes: 99500, 0500F (Initial prenatal visit), 0502F (Subsequent prenatal visit)

Pregnancy History: _____

LMP: _____ GA: _____ EDD: _____ FHT: _____ Fundal Height: _____

Cervical Exam (Dilation/Effacement/Station): ____/____/____ OB Lab Date: (Please attach): ____/____/____

OB U/S (Please attach): _____/_____/_____ Confirmed Diagnosis of Pregnancy: ☐ Y or ☐ N

Prenatal Substance Abuse Screen for Alcohol and Drugs

Advise the client responses are confidential. Any questions answered YES require further assessment/intervention.

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt the need to cut down on your drinking or drug use? ☐ Y or ☐ N
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Y or ☐ N
3. Have you ever felt bad or guilty about your drinking or drug use? ☐ Y or ☐ N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ Y or ☐ N

Provider Signature: _____ Date: _____/_____/_____

☐ OBGYN ☐ CNM ☐ PCP ☐ ARNP ☐ PA

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