Health & Human Resources

WEST VIRGINIA
PRENATAL RISK SCREENING INSTRUMENT

Name: Last	First	MI	Date of Birth:	Age:	Social Security #:

Address: Street	City	Zip Code	County of Residence:	Telephone #:	Alternate #:

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
(Check all that apply)

U.S. Citizen: ☐ Yes ☐ No

Married: ☐ Yes ☐ No

Insurance Source: ☐ Health Insurance ☐ No Insurance ☐ Medicaid #_____

Date of 1st Prenatal Visit: (MM/DD/YYYY): _____

Current Weight (lbs): _____

Height (Ft-inches): _____

BMI: _____

Blood Pressure: ☐☐☐ / ☐☐☐

Obstetrical History:
Gravida ☐☐ Para ☐☐☐☐☐☐
T P SAB EAB L

LMP (MM/DD/YYYY): _____

EDC (MM/DD/YYYY): _____

Date of Last Delivery: _____

Type of Delivery:
1st Trimester ☐ Miscarriage ☐ Abortion
2nd Trimester ☐ Miscarriage ☐ Abortion
☐ Preterm Birth ☐ Term Birth

Oral Health:	Yes	No
Sensitive/Bleeding Gums	☐	☐
Loose/Broken/Decayed Teeth	☐	☐
Dental visit within the last year	☐	☐

	Yes	No
Do you intend to breastfeed?	☐	☐
Are you currently breastfeeding?	☐	☐

Pregnancy Risk Factors:	Current Prog. Y	Current Prog. N	Prior Prog. Y	Prior Prog. N
Previous Cesarean Section	na	na	☐	☐
Low Birth Weight (<2500gm)	na	na	☐	☐
Gestational Diabetes	☐	☐	☐	☐
PIH/Preeclampsia	☐	☐	☐	☐
Placental Abruption	☐	☐	☐	☐
Placenta Previa	☐	☐	☐	☐
Cervical Incompetence	☐	☐	☐	☐
Abdominal Surgery	☐	☐	☐	☐
Opioid Replacement Treatment	☐	☐	☐	☐
Asst Reproductive Technology	☐	☐	☐	☐

	Current Prog. Y	Current Prog. N	Prior Prog. Y	Prior Prog. N
Fetal Reduction	☐	☐	☐	☐
Macrosomia	☐	☐	☐	☐
IUGR	☐	☐	☐	☐
Oligo/Polyhydramnios	☐	☐	☐	☐
Abnormal Amniocentesis	☐	☐	☐	☐
Abnormal AFP	☐	☐	☐	☐
Maternal Fetal Infection	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Rh Negative	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐

	Current Prog. Y	Current Prog. N	Prior Prog. Y	Prior Prog. N
Hepatitis C	☐	☐	☐	☐
Group B Strep	☐	☐	☐	☐
Pyelonephritis	☐	☐	☐	☐
History of PROM	na	na	☐	☐
Previous Stillbirth	na	na	☐	☐
Other/Unlisted Risk Factor:				

Advanced Maternal Age: ☐ Yes ☐ No
Bleeding during current pregnancy:
Trimester: ☐ 1st ☐ 2nd ☐ 3rd ☐ No

Family History:	Current Prog. Y	Current Prog. N	Prior Prog. Y	Prior Prog. N	Family History Y	Family History N
Multiple Gestation	☐	☐	☐	☐	☐	☐
Fetal Genetic/Structural Abnormalities	☐	☐	☐	☐	☐	☐

Medical Conditions:	Yes	No	On Meds		Yes	No	On Meds
High Blood Pressure	☐	☐	☐	STD	☐	☐	☐
Kidney Disease	☐	☐	☐	Seizures	☐	☐	☐
Diabetes	☐	☐	☐	Other	☐	☐	☐
Asthma	☐	☐	☐				
Heart Condition	☐	☐	☐				
Thyroid Disease	☐	☐	☐				

Psychosocial Risk Factors:	Yes	No
Disabled	☐	☐
Unemployed/Inadequate Income	☐	☐
Husband/Partner Unemployed	☐	☐
Homeless	☐	☐
Unstable Housing	☐	☐
Education <12 years	☐	☐
Currently in Foster Care	☐	☐
Inadequate Transportation	☐	☐
Inadequate Social Support	☐	☐
Unplanned Pregnancy	☐	☐
Nutritional Concerns	☐	☐
Eating Disorder	☐	☐
Domestic Violence	☐	☐
Difficulty with Reading & Understanding	☐	☐
Internet Access	☐	☐

Environmental Risk Factors:	Yes	No
Lead: House Built before 1978	☐	☐
Viral: Cats or Birds in Home	☐	☐
Tobacco: 2nd or 3rd Hand Smoke	☐	☐

Reasons for Late Entry Into Prenatal Care:	Yes		Yes
Does not apply	☐	Financial	☐
Insurance Enrollment Delay	☐	Child Care Issues	☐
Unaware of Importance of PNC	☐	Access to pregnancy testing	☐
Couldn't find a health provider	☐	Transportation	☐
Abortion desired/unsuccessful	☐	Other:	

Have either of your parents had a problem with drugs or alcohol? Yes ☐ No ☐
Has your partner had a problem with drugs or alcohol? Yes ☐ No ☐
Have you had a problem with drugs or alcohol in the past? Yes ☐ No ☐
Have you used drugs or alcohol during this pregnancy? Yes ☐ No ☐
Have you ever smoked cigarettes? Yes ☐ No ☐ I quit (when) _____
Do you currently smoke cigarettes? Yes ☐ No ☐ If yes, # of cigarettes per day: _____ Does your partner smoke? Yes ☐ No ☐
Have you ever been a victim of abuse or violence? Yes ☐ No ☐
Has your partner's anger ever worried or scared you? Yes ☐ No ☐
Have you ever felt down or hopeless? Yes ☐ No ☐
Have you lost interest in things you used to do for fun? Yes ☐ No ☐

Provider Name & Title:	Provider Telephone#:	Date:

I am interested in further follow-up. I give my consent for necessary referrals to be made. I understand that my participation in any referral services is voluntary and that all information provided will be held strictly confidential.

Patient Name (print):	Patient Signature:	Date:

PLEASE COMPLETE AND FAX TO (304) 957-0176

WV PRENATAL RISK SCREENING INSTRUMENT INSTRUCTIONS

The Prenatal Risk Screening Instrument (PRSI) is intended to promote early and accurate identification of prenatal risk factors. Prenatal risk screening is conducted at the first prenatal visit. If the patient answers "Yes" to any pregnancy or medical risk factor, a Maternal Fetal Medicine consultation should be considered.

General Instructions
Print clearly. Complete the form accurately and completely. When asked to select "Yes" or "No", choose only one option.

Patient Information
Name (List patient's Last Name, First Name & Middle Initial)
Date of Birth (List patient's date of birth as MM/DD/YYYY)
Age (Use the patient's current age)
Social Security Number (List patient's social security number; if patient is undocumented or a non-citizen use 000-00-0000)
Address (Use current address where the patient resides)
County of Residence (List the West Virginia County that patient's address is located)
Telephone Number (Use a current telephone number & alternate number, if applicable, where patient can be reached)
Race/Ethnicity (Check all that apply)
U.S. Citizen (Choose only one option)
Married (Choose only one option)
Insurance Source (Select type of insurance source that patient currently has; if Medicaid, list Medicaid number)

Entry into Prenatal Care
Date of First Prenatal Visit (Enter the date of the patient's initial medical examination during this pregnancy)
Current Weight (List patient's current weight in pounds)
Height (List patient's current height in feet/inches)
BMI (Info listed for patient's weight and height will be combined to determine her BMI Score)
Blood Pressure (List patient's blood pressure reading at time of this visit)

Obstetrical History
Gravida (Enter # of pregnancies in the boxes; include current pregnancy in this number. If Gravida >1, the Para field must be completed.)
Para (This is the # of: T=Term Deliveries; P= Preterm Deliveries; SAB=Spontaneous Abortions; EAB=Elective Terminations; & L=Live Births)
LMP (List date of last menstrual period)
EDC (List estimated date of confinement)
Date of Last Delivery (List patient's last pregnancy delivery date, if applicable)
Type of Delivery (Select type of delivery patient had from last pregnancy, if applicable)

Oral Health
Select "Yes" or "No". If patient answers "Yes" to any of the questions, please consider a referral to a dentist or provide patient education.

Breastfeeding
Select "Yes" or "No" to the questions regarding breastfeeding.

Pregnancy Risk Factors
Select "Yes" or "No" to indicate the presence of risk factors in the patient's current and/or prior pregnancy(ies).

Advanced Maternal Age
Select "Yes" or "No" if patient will be 35 or older at time of delivery.

Bleeding During Current Pregnancy
If "Yes", select the trimester(s) that bleeding occurred. Select "No" if bleeding did not occur.

Family History
Select "Yes" or "No" to indicate the presence of risk factors in the patient's current and/or prior pregnancy(ies) and/or whether there is a family history for the selected risk factors.

Medical Conditions
Select "Yes" or "No" to indicate whether the patient currently has the listed medical risk factor and/or is taking medication for the condition.

Psychosocial Risk Factors
Select "Yes" or "No" for each risk factor listed.

Environmental Risk Factors
Indicate by selecting "Yes" or "No" whether the patient has been exposed to listed items in their environment. A patient who lives in a house built before 1978 is at risk for exposure to lead paint.

Reasons for Late Entry into Prenatal Care
Complete this section only when a patient enters prenatal care in the 2nd or 3rd trimester. Fill in "Yes" for all reasons that apply.

Additional Screening Questions
These questions are used as a screening tool to begin discussion about use of drugs, alcohol, tobacco and/or abuse. Advise the patient that the responses she provides are confidential and may only be used for her evaluation and treatment. Any patient who answers "Yes" to one or more questions may warrant further assessment and follow-up.

Provider Information
List name, title and telephone number of provider completing the PRSI; list date the form was completed.

Consent
Patient's participation in any referral services is voluntary and her consent must be provided. If patient is interested in further follow-up/referrals, she must print name, sign and date the form. If patient is not interested in referral services, please leave this section blank.

Completion
Fax the form to (304) 957-0176. Do not include coversheets. Check to be sure the correct side of the form is transmitted. Fax only one form per patient; do not re-fax a patient's form. Duplicate faxes create problems with processing.