Transfer/Lost to Follow-up/Other: _____

Miami County Prenatal Demographic Sheet

Please complete section 1, 2, and 3.

Section 1

Legal Name: _____ Date of Birth: _____ Age: _____

Maiden/Other Name _____ Marital status: __S __M __Sep __D __W

Race: __ Am. Ind/Alaskan __Asian __Black __Multiracial __Pacific Is/Hawaiian __Other __White

Number of people in Household: ___ SS#: _____ Allergies: _____

If under 18 years, guardians name: _____

Home Address _____ City____ State___ Zip _____

Township: _____Primary #: _____ Emergency #: _____

May we call you: Yes/No Text: Yes/No Leave message at Primary #: Yes/No

Section 2

Employment: _____ Job description: _____

Medical insurance: _____

Applied for Medicaid: Yes-When: _____/No-Why not: _____ WIC: Yes/No

Section 3

Father of Baby Name: _____ Age: ____ Phone: _____

Referred to clinic by: _____ If here before, year seen: _____

Staff Complete

C-Section: No/Yes __# Due Date: _____ Chart Faxed ___, ___. ___, __

Diagnosis: _____

_____

Ohio Medicaid _____ Effective Date: _____

HMO/Medicaid _____ Member ID: _____

Self Pay ___% CPA Assistance _____ Barriers: _____

Problem List: _____

_____

Missed 3 consecutive appointments: No/Yes-Action: _____

Self –Declaration of Income

My HOUSEHOLD'S gross income (income before taxes) is $_____(week/month)

We receive$_____child support (week/month)

We receive $_____cash assistance from Dept. of Jobs and Family Services.

We receive$_____Social Security Benefits

*If you have recently become employed and do not have a pay stub on which to base your monthly income, please list your hourly rate, how many hours per week what you work, and how often you will be paid. We can project your gross monthly income.

I will be paid $_____per hour_____I expect to work_____hours per week.

I will be paid weekly/ bi-weekly/monthly (please circle)

My spouse (or significant other) will be paid weekly/ bi-weekly/monthly

Hourly rate $____x_____hours worked = $_____

____I have private insurance. Please provide a copy of your insurance card.

____I have Medicaid/Caresource/Buckeye/Paramount/UHC Community Plan/Molina. Please provide a copy of your insurance card.

____I do not with to disclose my household income, I understand that I must pay 100% of the charges at the time of services.

I verify that the information I have provided is correct to the best of my knowledge. Program officials may verify the information on this form. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution. I hereby acknowledge receiving a copy of this form if requested.

SIGNATURE_____DATE_____

WITNESS_____DATE_____

CONSENT FOR TREATMENT

NAME_____ DOB: _____

I hereby request and consent to the necessary examination, laboratory procedures and treatment as provided by MIAMI COUNTY PUBLIC HEALTH during the prenatal and immediate postpartum period.

- The above include, but are not necessarily limited to: pelvic and breast examination, pap (cancer) smear, prenatal blood testing (hemoglobin blood test to measure iron for anemia), drug screening, serology blood test for syphilis, height and weight, urinalysis (chiefly for sugar and protein), gonorrhea/chlamydia culture, HIV testing, and urine or serum pregnancy test.
- My signature provides consent for treatment; acknowledgement of notification of the **Notice of Privacy Practices**, verification of voluntarily participating, and verification that all information is accurate and correct to the best of my knowledge. I am aware that I am responsible for the contracted price determined by insurance or by the sliding fee scale.

Follow-up care of all reportable communicable diseases will be reported to OHIO DEPARTMENT OF HEALTH by MIAMI COUNTY PUBLIC HEALTH. The health department will make contact if evaluation and treatment of positive tests are not completed within seven (7) days of the test results. The follow-up nurse will handle all other abnormal laboratory testing. The patient will be notified and the clinician will evaluate the lab work for consideration of treatment for further evaluation.

I, as a patient of MIAMI COUNTY PUBLIC HEALTH, do understand that I will be seen as a patient at the MIAMI COUNTY PUBLIC HEALTH site at regularly scheduled intervals throughout my pregnancy. Since I will be attended by physicians from UPPER VALLEY MEDICAL CENTER, I am expected to deliver at Upper Valley Medical Center in Troy, Ohio.

I hereby grant permission to MIAMI COUNTY PUBLIC HEALTH PRENATAL WELLNESS CENTER to exchange all information concerning my care and treatment with UVMC or the hospital of delivery.

SIGNATURE OF PATIENT_____ DATE _____

SIGNATURE OF GUARDIAN/PARENT_____

I witness the fact the patient read and said she understood the general consent and the Authorization of Release of Information.

WITNESS _____ DATE _____

Maternal Child Health Program
Consent Form

The Maternal Child Health Program (MCHP) receives money from the Ohio Department of Health (ODH) to provide public health services. All MCHP projects must report information to the ODH about its clients and health care services provided.

A client's name, social security number, and other personally identifying information is requested to evaluate the impact of combined government programs on the health of Ohio's children and families.

ODH may give general information about MCHP clinics in summary form for federal reports or to state legislators but will not release information that would identify a client by name or social security number.

Clients have the right not to give the social security number or other personally indentifying information to ODH. If a client decides not to give ODH his or her social security number or name, that refusal will not affect their eligibility to receive health care services.

*I, (print name)*_____ *give the clinic permission to include my name, birth date and social security number on the Department's forms. Permission may be withdrawn at any time with respect to future disclosures.*

Consent: _____ Date: _____

I, (print name) _____ do NOT give consent to include my name, birth date and social security number on the clinic record to be sent to the Ohio Department of Health.

Refusal: _____ Date: _____

ACKNOWLEDGMENT OF NOTICE OF HEATLH INFORMATION PRIVACY PRACTICE

I hereby acknowledge receipt/understanding of Miami County Public Health's Notice of Health Information Privacy Practices. PLEASE PRINT YOUR NAME, SIGN AND DATE AS INDICATED BELOW:

Name_____Signature:_____Date_____

Pre-natal Social Assessment

Name:_____ Due Date:__/__/__ Today's Date:__/__/__

Please answer the following question about your **PREGNANCY:**

1. Was this pregnancy planned?	Yes	No
2. Do you have fears of being pregnant?	Yes	No
3. Did you use any birth control?	Yes	No
4. Do you have questions about adoption?	Yes	No
5. Does the baby's Dad know you are pregnant?	Yes	No
6. Did the father want you to become pregnant?	Yes	No
7. Does the father help you in any way now?	Yes	No
8. Will the father help you with the baby after it is born?	Yes	No

Please answer the following questions about your **HEALTH:**

1. Do you have any medical problems that worry you?	Yes	No
2. Have you ever used any street drugs?	Yes	No
3. Have you ever been in a recovery program for drugs/alcohol?	Yes	No
4. Do you currently drink any kind of alcohol?	Yes	No
5. Has drinking ever caused problems for you?	Yes	No
6. Do you ever feel nervous or depressed?	Yes	No
7. Have you ever talked to a counselor?	Yes	No
8. Have you ever thought about or tried to commit suicide?	Yes	No

Please answer the following questions about **FAMILY MATTERS:**

1. Are there any problems between you and the baby's father?	Yes	No
2. Have you ever been abused (physically, mentally, verbally)?	Yes	No
3. Are there any problems in the way you and your parents get along?	Yes	No
4. If you have kids, any problems with how you get along with them?	Yes	No
5. Have you ever lived in Foster Care, or an adoptive home?	Yes	No
6. Have any of your kids ever lived in foster care or adoptive homes?	Yes	No

Please answer these questions about **EDUCATION/WORK:**

1. Are you still in school?	Yes	No
2. Are you thinking of going back to school?	Yes	No
3. Would you like some help in continuing your education?	Yes	No
4. Will you need help with childcare?	Yes	No

PLEASE SEE REVERSE SIDE

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the past two **weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score