**Pregnancy Behavioral Risk Assessment**

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PASTE “C Label” HERE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First M.I. Last

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Dept.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle one:** **Z33.1** - (Pregnancy) or **Z39.2** - (Postpartum)

**OB/GYN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency/Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expected Delivery Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital most likely for delivery:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Location of hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Phone**: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_***OR*** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** of health care provider or their duly authorized **Signature** of individual completing screening form, if different representative confirming pregnancy diagnosis

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| --- | --- | --- | --- |
| **Health care provider** After asking ALL screening questions, return to question #1 and review with patient, checking suggested actions taken below.  Offer every patient a fact sheet on the importance of abstinence from alcohol, tobacco, and other drugs during pregnancy.  **Patient** Women’s health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women’s health is also affected when those same by problems are present in people close to us. By “alcohol,” we mean beer, wine, wine coolers, or liquor.  *(Institute for Health and Recovery)* | | | |
| **Screening Questions** | **Answers** | **Suggested Action** |
| **1**. Did any of your **parents** ever have a problem with alcohol or drug use?  **2**. Does your **partner** have any problem with alcohol or drug use?  **3.** Do any of your close **friends** have any problem with alcohol or drug use? | **\_\_\_ Yes \_\_\_No**  **\_\_\_ Yes \_\_\_No**  **\_\_\_ Yes \_\_\_No** | **If YES to questions #1, 2, or 3:**   * Stated concern that any of these can increase risk for developing alcohol and drug problems |
| **4**. In the month before you knew you were pregnant, how many days did you smoke cigarettes or use **tobacco**? (Even one cigarette per day equals one day.)  **If ANY DAYS, ask:**  In the last month, how many days did you smoke cigarettes, or use any form of tobacco?  **5.** In the month before you knew you were pregnant, how many servings of **alcohol** (beer, wine, wine coolers, or hard liquor) did you drink?  **If ANY SERVINGS, ask:**  In the last month, how many days a week did you drink alcohol?  **6.** Have you ever used **other drugs** such as: cocaine, methamphetamines, amphetamines, tranquilizers, heroin, prescription pain pills (other than as prescribed), marijuana, LSD, PCP, or inhalant drugs (fumes from aerosol cans, or other fumes) in the past?  **If YES, ask:**  In the month before you knew you were pregnant, how many times did you use any of the drugs that you have used in the past?  **If ANY TIMES, ask:**  In the last month, how many days a week did you use the drugs you mentioned? | **\_\_\_\_\_Days (#)**  **\_\_\_\_\_ Days (#)**  **\_\_\_\_\_Servings (#)**  **\_\_\_\_\_Days (#)**  **\_\_\_Yes \_\_\_No**  **\_\_\_\_\_Times (#)**  **\_\_\_\_\_Days (#)** | **If ANY cigarette, alcohol, or drug use in questions #4- #6:**  **Completed Brief Intervention:**   * + Stated concern   + Advised abstinence   + Discussed patient’s reaction   + Agreed on a plan of action   **Completed Referral:**   * Kentucky’s Tobacco Quit Line (1-800-QUIT-NOW) * Behavioral health provider for assessment/ treatment   Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * KY-Moms MATR for case management and linkage with behavioral health services * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **7**. Are you feeling at all **unsafe** in any way in your relationship with your current partner or with a previous partner? | \_\_\_Yes \_\_\_No | **If YES to question #7:**   * Followed office procedure for partner abuse disclosure |
| **8.** Over the past few weeks, has **worry, anxiety, depression or sadness** made it difficult for you to do your work, get along with others, or take care of things at home? | \_\_\_Yes \_\_\_No | **If YES to question #8:**   * Stated concern about the effects of depression and anxiety on the baby * Referred to behavioral health provider for assessment/ treatment   Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\*Statewide KY-Moms: Maternal Assistance Towards Recovery (MATR) contact: Katie Stratton 502-782-6192**  **\*** Adapted from screening instrument created by Robert Walker, University of Kentucky, Center on Drug and Alcohol Research. | | |