STATE OF NEW JERSEY
PERINATAL RISK ASSESSMENT

Third Trimester (3TM)

PATIENT INFORMATION

PROVIDER INFORMATION

Date Completed / / **Practice**

Provider NPI **Group/Billing NPI**

Planned Delivery Site

PATIENT INFORMATION

Chart Number **First Name** **Last Name**

DOB / / **Street Address** **City**

Zip **State** **County** **Apt./Suite/Other**

Primary Phone **Email**

Preferred Contact ○ Text ○ Call ○ Email

HEALTH INSURANCE

Insurance Type: ☐ NJ FamilyCare ☐ Medicaid PE ☐ Medicaid FFS ☐ NJ Supplemental Prenatal and Contraceptive Program (NJSPCP) ☐ Medicare ☐ Commercial ☐ Uninsured/Self Pay

Medicaid MCO:

Medicaid ID or CCN Number **Insurance ID** **Insurance Effective Date**

PREGNANCY RISK FACTORS

PREGNANCY RISK FACTORS

☐ All Pregnancy Risk Factors Negative

	Yes	No	Unk
Active Herpes	○	○	○
Cytomegalovirus	○	○	○
Family History of Childhood Hearing Loss	○	○	○
Influenza	○	○	○
Listeria	○	○	○
Lyme Disease	○	○	○
Malaria	○	○	○
Parvovirus	○	○	○
Rh Sensitization	○	○	○
Rubella	○	○	○
Toxoplasmosis	○	○	○
Varicella Zoster	○	○	○
West Nile Virus	○	○	○
Zika Virus	○	○	○

	Yes	No
Abdominal Surgery	○	○
Abdominoplasty	○	○
Appendectomy	○	○
Bariatric Surgery	○	○
Bowel Resection	○	○
Cholecystectomy	○	○
Exploratory Laparotomy	○	○
Hernia Repair Surgery	○	○
Abnormal Amniocentesis	○	○
Abnormal Fetal Testing	○	○
Alcohol Use	○	○
BMI Concern *(system populates from BMI)*	○	○
Cervical Insufficiency	○	○
Eclampsia	○	○
Fetal Genetic/Structural Abnormalities	○	○
GBS Bacteriuria	○	○
Gestational Diabetes	○	○
Insulin Dependent	○	○
Gestational Hypertension	○	○
Hepatitis A	○	○
Hepatitis B	○	○
Hepatitis C	○	○
Hyperemesis	○	○

	Yes	No
Illicit Drug Use	○	○
Cocaine	○	○
Hallucinogens	○	○
Heroin or Other Opioids	○	○
Inhalants	○	○
Other Non-Opioid Prescription Drugs	○	○
Macrosomia (weight is greater than 4000 g or 8 lbs 13 oz)	○	○
Marijuana Use	○	○
Maternal Fetal Infection	○	○
Multiple Gestation	○	○
Opioid Dependence	○	○
Opioid Replacement Treatment	○	○
Pelvic Surgery	○	○
Cone Biopsy	○	○
Cryosurgery	○	○
D&C	○	○
GYN Surgery	○	○
Hysteroscopy	○	○
Myomectomy	○	○
Ovarian Cystectomy	○	○
Prolapse Repair	○	○
Salpingectomy/Ostomy	○	○
Placenta Previa	○	○
Pyelonephritis	○	○
Rh Negative	○	○
Urinary Tract Infection	○	○

PATIENT'S CURRENT MEDICAL CONDITIONS

PATIENT'S CURRENT MEDICAL CONDITIONS

	Yes	No	Unk	On Meds
Abnormal Pap Smear	○	○	○	
Active Tuberculosis	○	○	○	☐
Allergies	○	○	○	☐
Anemia	○	○	○	☐
Asthma	○	○	○	☐
Blood Disorder				
Blood Clotting	○	○	○	☐
Blood Dyscrasia	○	○	○	☐
Sickle Cell Disease	○	○	○	☐
Sickle Cell Trait	○	○	○	
Thalassemia	○	○	○	☐
Other	○	○	○	☐

	Yes	No	Unk	On Meds
Cancer	○	○	○	☐
Specify:				
Chronic Hypertension	○	○	○	☐
Congenital Abnormalities	○	○	○	
Cystic Fibrosis	○	○	○	☐

If Yes, offer patient referral to Alma: Moms supporting Moms peer support program. Referral link will appear when form is entered on PRA Connect.

Depression	○	○	○	☐
Diabetes	○	○	○	☐
Insulin Dependent	○	○	○	

	Yes	No	Unk	On Meds
Epilepsy/Seizure Disorder	○	○	○	☐
Heart Condition	○	○	○	☐
HIV Positive/AIDS	○	○	○	☐
Liver Disease	○	○	○	☐
Lupus	○	○	○	☐
Mental Illness	○	○	○	☐
Neurological Condition	○	○	○	☐
Phlebitis/DVT	○	○	○	☐
Renal Disease	○	○	○	☐
Seizures	○	○	○	☐

	Yes	No	Unk	On Meds
STD or STI				
Bacterial Vaginosis	○	○	○	☐
Chlamydia	○	○	○	☐
Genital Herpes	○	○	○	☐
Gonorrhea	○	○	○	☐
HPV	○	○	○	☐
Syphilis	○	○	○	☐
Trichomoniasis	○	○	○	☐
Thyroid Disease				
Hyperthyroidism	○	○	○	☐
Hypothyroidism	○	○	○	☐
Uterine Abnormalities	○	○	○	

ADD'L INFO

Current Medications
(Include name and dosage of all medications currently being taken.)

Additional Information
(Include specifics about health conditions or identified risk factors for insurance partners to best serve your patient.)

PSYCHOSOCIAL RISK FACTORS

PSYCHOSOCIAL RISK FACTORS

	Yes	No	Unk
Currently in Foster Care	○	○	○
Disabled	○	○	○
Hearing	○	○	○
Mobility	○	○	○
Vision	○	○	○
Other	○	○	○
Other, specify:			
Receiving SSI/SSD	○	○	○

	Yes	No	Unk
Domestic/Interpersonal Violence	○	○	○
Eating Disorder	○	○	○
Education Less Than 12 Years	○	○	○
Financial Concerns	○	○	○
Food Insecurity	○	○	○
Homeless	○	○	○
Inadequate Social Support	○	○	○
Nutritional Concerns	○	○	○

	Yes	No	Unk
Partner is Unemployed / No Partner in Household	○	○	○

If Yes, offer patient referral to Alma: Moms supporting Moms peer support program. Referral link will appear when form is entered on PRA Connect.

Perinatal Depression/Mood Disorder	○	○	○
Transportation Barriers	○	○	○
Trauma	○	○	○
Unemployed	○	○	○
Unplanned Pregnancy	○	○	○
Unstable Housing	○	○	○

PRENATAL INFORMATION

PRENATAL CARE

EDD / /

# of Prenatal Care visits

Prenatal Vitamins
☐ Pre-pregnancy ☐ 1st Trimester ☐ None ☐ Unknown

Blood Type
○ A ○ B ○ AB ○ O ○ Unavailable
○ Positive ○ Negative

PRENATAL TESTS + PROCEDURES

HIV

Was patient known HIV positive entering prenatal care?
(If Yes, skip HIV testing questions.)
○ Yes ○ No

Was patient counseled regarding the benefits of HIV testing during the pregnancy?
○ Yes ○ No

Was patient tested for HIV during the pregnancy?
○ Twice
○ Once
○ Not Tested
○ Unknown

Date of 1st test: / /

Date of 2nd test: / /

Source of HIV Information ☐ Patient's Medical Records ☐ Patient's Verbal History ☐ Medical Provider Interview ☐ None

Hepatitis B

Hepatitis B Serology Obtained?
○ Yes ○ No ○ Unknown

Date of most recent HBSAg test / /

Hepatitis B Surface Antigen Positive? (HBSAg)
○ Yes ○ No ○ Unknown

Syphilis

Syphilis Serology Obtained?
○ Yes ○ No ○ Unknown

Date Sample Obtained / /

Syphilis Serology Result
○ Positive ○ Negative ○ Unknown

Prenatal Procedures (Select all that apply.)

☐ Amnio Assess Lung Maturity
☐ Amnio Genetic Screening
☐ Amnio Other Purpose
☐ Cervical Cerclage
☐ Chorionic Villus Sampling (CVS)
☐ External Cephalic Version Attempted
○ Successful
○ Failed
☐ Selective Fetal Reduction
☐ Tocolysis
☐ None of these procedures performed

Fetal Ultrasound Performed
○ Yes ○ No

If so, when?
☐ 1st Trimester
☐ 2nd Trimester
☐ 3rd Trimester

# of Ultrasounds

Diagnoses made by ultrasound during this pregnancy:
☐ Intrauterine Growth Restriction (IUGR)
☐ Oligohydramnios
☐ Polyhydramnios
☐ Prenatal Fetal Cardiac Anomalies
☐ Prenatal Fetal Non-Cardiac Anomalies
☐ None of these diagnoses made

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4Ps PLUS *Read 4Ps Plus questions out loud during patient's office visit.*

4Ps PLUS

☐ **4Ps Plus interview not conducted during visit.**

Did either of your parents have a problem with drugs or alcohol?	○ Yes	○ No
Does your partner have any problem with drugs or alcohol?	○ Yes	○ No
Have you ever felt manipulated by your partner?	○ Yes	○ No
Have you ever felt out of control or helpless?	○ Yes	○ No
Over the past 2 weeks have you felt down, depressed or hopeless?	○ Yes	○ No
Over the past 2 weeks have you felt little interest or pleasure in doing things?	○ Yes	○ No
Have you ever drunk beer/wine/liquor?	○ Yes	○ No
In the month before you knew you were pregnant, how many cigarettes did you smoke?	○ **Any***	○ None
In the month before you knew you were pregnant, how much beer/wine/liquor did you drink?	○ **Any***	○ None
In the month before you knew you were pregnant, how much marijuana did you use?	○ **Any***	○ None

4Ps PLUS FOLLOW-UP

**Follow-up questions required if 'Any' above selected.*

	Refer for Assessment		Prevention Education		No Referral Needed
In the month before you knew you were pregnant, about how many days a week did you usually...	**Every day**	**3-6 days/week**	**1-2 days/week**	**< 1 day/week**	**No drugs/drinks**
drink beer, wine or liquor?	○	○	○	○	○
use any drug such as marijuana?	○	○	○	○	○
use any drug such as cocaine, or heroin or methamphetamine or any other drug?	○	○	○	○	○
take any medication not prescribed for you?	○	○	○	○	○
And now, about how many days a week do you usually...					
drink beer, wine or liquor?	○	○	○	○	○
use any drug such as marijuana?	○	○	○	○	○
use any drug such as cocaine, or heroin or methamphetamine or any other drug?	○	○	○	○	○
take any medication not prescribed for you?	○	○	○	○	○

TOBACCO/ NICOTINE USE

☐ **Nonsmoker**

How many cigarettes did you smoke per day during each of the following time periods? If none, enter zero (0).

1st Trimester ____
2nd Trimester ____
3rd Trimester ____

If any, offer patient referral for Tobacco/Nicotine Cessation in section below..

REFERRALS + EDUCATION

Use Referral Needed column to indicate items for Connecting NJ to initiate.

Ask all patients: *Are you interested in learning more about programs and services to support pregnancy and family wellness?* Select *Send Referral* to link patient to Connecting NJ and/or Family Connects NJ.

AUTOMATED REFERRALS

Connecting NJ*

Connecting NJ (CNJ) provides referrals to local community resources, programs, and services to support patients and families. Staff contact patients to offer individualized, confidential, and caring support. Select *Send Referral* to connect patient to a network of partners dedicated to helping NJ families thrive, including Nurse Family Partnership, Parents as Teachers, and Healthy Families.

Send Referral	Declined	Receiving Services	Not NJ Resident
○	○	○	○

Notes for Connecting NJ staff: ____

Family Connects NJ*

Family Connects NJ (FCNJ) is a program that connects parents with a specially trained nurse for a personalized follow up visit at home within the first two weeks after their child's birth. Visits are offered to all families at no cost, regardless of income, insurance, or immigration status. Services are available to birth, adoptive, and resource families with a newborn, as well as parents experiencing a stillbirth or loss of their newborn. Services are currently available in select NJ counties. Select *Send Referral to* connect patient to FCNJ.

Send Referral	Declined	Receiving Services	County Not Live or Not NJ Resident
○	○	○	○

Notes for Family Connects NJ staff: ____

Tobacco/Nicotine Cessation*

Mom's Quit Connection (MQC) for Families provides free and individualized counseling to quit or cut down on tobacco/nicotine and/or vaping and help with relapse prevention for pregnant individuals, partners, and anyone caring for a child 8 years and younger. Select *Send Referral to* connect patient to MQC.

Send Referral	Declined	Not Needed	Not NJ Resident
○	○	○	○

REFERRALS + EDUCATION

		Education Provided	Referral Provided	Receiving Services	Referral Needed	Declined	Not Needed
Behavioral Health Assessment	☐		○	○	○	○	○
Mental Health Assessment	☐		○	○	○	○	○
Substance Use Assessment	☐		○	○	○	○	○
Breastfeeding Support	☐		○	○	○	○	○
Childbirth Education	☐		○	○	○	○	○
Childcare Services	☐		○	○	○	○	○
DCP&P	☐		○	○	○	○	○
Dental Referral	☐		○	○	○	○	○
Diabetes Care Program	☐		○	○	○	○	○
Domestic Violence Assessment	☐		○	○	○	○	○
Emergency Assistance/TANF/GA	☐		○	○	○	○	○
Food Stamps/SNAP	☐		○	○	○	○	○
Nutritional Consult	☐		○	○	○	○	○
Preterm Labor Prevention	☐		○	○	○	○	○
SSI	☐		○	○	○	○	○
Substance Use Prevention Education	☐		○	○	○	○	○
WIC	☐		○	○	○	○	○

***Indicates Automated Referral**