OREGON MATERNITY CASE MANAGEMENT INITIAL ASSESSMENT

Oregon Health Authority

Client Name	DOB	Age	S M D W
Prenatal Care Provider (If none, referral made ❑)	Referral Source:		EDC____________

Prenatal Care began at ______weeks | ____ Gravida_____Term ____Preterm____ SAB____ TAB____ Living

*Requires documentation

Problem *	No Problem	
		PHYSICAL/DENTAL/MENTAL
		Obstetric History & Experience
		Mental Illness
		Physical Illness
		Dental Health
		Special Needs
		PSYCHOSOCIAL/BEHAVIORAL
		Substance Use: Self/Significant Others
		Tobacco Exposure: Active/Passive
		STD/HIV Risk Assessment
		DEVELOPMENTAL/EDUCATIONAL
		Last Grade Completed
		Literacy
		Mental, emotional or physical condition affecting learning
		Communication/Special Needs
		TRANSPORTATION
		SELF-ASSESSED STRESS LEVEL ❑ Low ❑ Med ❑ High

❑ **Meets criteria for High Risk Case Management**

❑ **RELEASE OF INFORMATION**/Date:________

*Requires documentation

Problem *	No Problem	
		ENVIRONMENTAL
		Housing & Living Situation
		Guns (locked & unloaded)
		Phone
		Smoke Alarm (installed & working)
		Exposure to Lead
		Exposure to Toxins
		Pets in Home
		NUTRITION
		Diet
		Pre-pregnant Weight
		Body Image
		Prenatal Vitamins/Folic Acid
		EMOTIONAL/RELATIONSHIPS
		Domestic Abuse
		History of Sexual Abuse
		Suicide Ideation/Attempt
		Depression/Anxiety
		Support System
		Self-Esteem
		Father of Baby Involvement

Form Sent To

Completed By

Agency

Date

Referred To: ______________________________

NOTES

Oregon Health Authority

OREGON MATERNITY CASE MANAGEMENT
Client Service Plan

Client Name	DOB	EDC

Client Strengths

Client Concerns

Case Manager Concerns

DATE	PROBLEM	CLIENT'S GOALS OR PLAN	Outcome: Met	Outcome: Partially Met	Outcome: Not Met

		PROGRESS TOWARDS GOALS/CASE MANAGER NOTES

Discharge Summary/Plan:

Signature	Printed Name	Agency	Date