Key:

- (pink circle) Risk factor points to be added up to determine patient risk for having a preterm birth or low birth weight baby
- (purple box) Reason to refer, regardless if the screening score is 6 or higher
- (blue box) Required information to **allow contact with patient**; it's important to note that the screening form should be entirely completed and that the patient information section is required of **ALL** prenatal patients

Patient Information Section

- **Patient demographic information** is required for ALL prenatal patients
- **Social Security #** is not needed but can be helpful
- **If patient declines to enter this information**, then per FL Statutes, this responsibility falls on the provider (all information is CONFIDENTIAL)

Patient Signature Section

Patient signature line: With her signature, patient gives her consent to be screened and for the form to be shared so services can be offered if she's referred; patients should be encouraged to consent.

Patient Initials: She must initial the **YES** if patient wants to receive services and if provider wants to refer.

***Decline Signature:** Although screening is voluntary, it is highly encouraged for patients to compete the screening form. But if she refuses screening, she signs here. These will be rare occurrences if a woman has a full understanding of the purpose of screening.

Florida Statute 383.14 requires prenatal providers to complete a Prenatal Risk Screen for ALL pregnant women during their FIRST prenatal visit. As a courtesy to you, Healthy Start pays a courier service to pick up your completed forms. Forms should be completed in their entirety and placed in a sealed envelope to be picked up via your next scheduled pick-up date.

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: ____________________

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☒ 1
2. Are you married now?	☐	☒ 1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☒ 1	☐
7. In the last month, have you felt alone when facing problems?	☒	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☒	☐
10. Do you have trouble paying your bills?	☒	☐

11. What race are you? Check one or more.
☐ White ☒ 3 Black ☐ Other ____________

12. In the last month, how many alcoholic drinks did you have per week?
__X__ drinks 1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
__X__ cigarettes 1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.......?
☐ pregnant now ☐ pregnant later ☒ 1 not pregnant

15. Is this your first pregnancy?
☒ 2 Yes ☐ No If no, give date your last pregnancy ended: Date: (month/year)__________

16. Please mark any of the following that have happened.
☒ 3 Had a baby that was not born alive
☒ 8 Had a baby born 3 weeks or more before due date
☒ 3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	~~Social Security Number:~~	Date of Birth (mo/day/yr):	17. Age: ☒ 1 <18
Street address (apartment complex name/number):	County:	City: State: Zip Code:	
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance ______ ☐ No Insurance ☐ Other ______	Best time to contact me:	Phone #1 ______ Phone #2 ______	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: ______________________ **Date:** ______________

Please initial: ________ Yes ________ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

★ If you do not want to participate in the screening process, please complete the patient information section only and sign below:

Signature: ______________________ *Date:* ______________

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: ____ lbs. Height: ____ ft. ____ in. BMI: ____	☒ 1 < 19.8 ☒ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☒ 1 Yes
		20. Trimester at 1st Prenatal Visit? ____________	☒ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: ____________ ☐ No	☒ 2 Yes
Healthy Start Screening Score: ______	**Check One:** ☒ Referred to Healthy Start. If score <6, specify: ______ ☐ Not Referred to Healthy Start.		
Provider's/Interviewer's Signature and Title		**Date (mo/day/yr)**	

DH 3134, 04/08, stock number 5744-100-3134-7

Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred; PINK—Retained in patient's record; GREEN—Patient's Copy

The screening form's purpose is to determine if a patient is considered **at-risk for having a baby born prematurely or low birth weight, both leading causes of infant mortality**

All information is kept **strictly confidential**; if not referred for services it is used for data purposes only; if referred, **services can be provided to reduce risk-factors and improve birth outcomes**

Services are provided at no cost to patients and are provided to **ANY pregnant woman** regardless of income or insurance status (focus is on risk factors)

Provider Information Section

- **#18 BMI:** use back of yellow carbon copy to determine
- **#19 Pregnancy Interval:** use date provided from Q #15 and LMP to determine
- **#20 Trimester at 1st Prenatal Visit:** use date signed and LMP to determine
- **Screening Score:** add up the screening score (circled in pink) to determine referral status
- **Referral status:**
  Check "*Referred*" if
  - ➞ Score is 6 or higher
  - ➞ Any highlighted purple boxes
  - ➞ Your professional judgment

  If you check "*Not Referred*", the screening form is used for data-purposes only.

  WHEN IN DOUBT, REFER!!
- **Provider signature:** provider staff are required to sign and date form

Know how to submit your forms!
White and yellow- submit to Healthy Start
Pink - put in patient's medical record as proof of screening
Green - give to and review with patient
Courier service - the responsibility of submitting screening forms falls on providers; in Orange County Healthy Start provides the courtesy courier service

FOR MORE INFORMATION:

Contact your Healthy Start representative at:

Ph: 407-228-1483

C: 407-342-8788

F: 407-228-1485

383.14

FLORIDA STATUTE

mandates that all prenatal providers complete a Prenatal Risk Screen for EVERY pregnant woman at her FIRST prenatal visit

WHAT TO DO BEFORE SCREENING FORM SUBMISSION?

1. **Florida Statutes-Rule 64C-7.009 requires you, the provider, to offer an explanation of Healthy Start to your prenatal patients when you issue the screen as well as review her risk-status as determined by the screening form (you must score and check the referral status). TIP: You may find our marketing material helpful**
2. **After the screening form has been completed, review all fields to ensure the form has been entirely filled out *before the patient leaves!***
3. **Reserve the top white and yellow copies to be submitted to Healthy Start, maintain the pink copy in the patient's medical record and return the green copy to the patient**
4. **Place *completed* forms in a sealed envelope and have ready for your next scheduled courier pick up day**

WHAT HAPPENS AFTER SCREENING?

Referred patients

- Are contacted by *Connect* staff and offered services
- If interested then services are provided as wanted

Nonreferred patients

- Screening information is kept confidential, is not shared, and no further action is taken

WHOM TO REFER FOR HOME VISITING SERVICES?

ANY pregnant woman, regardless of income level or insurance status. This includes:

- A patient who has scored 6 or higher on the screening form
- A patient who in the provider's professional judgment is at risk, regardless of her screening score

WHAT SERVICES ARE PROVIDED TO REFERRED PATIENTS?

Services are free and voluntary and include:

- **Prenatal Education**
- **Breastfeeding education & support**
- **Nutrition education**
- **Parenting education**
- **Newborn care**
- **Postpartum care education**
- **Interconception education**
- **Smoking reduction**
- **Stress reduction**
- **Referrals to other community agencies**

Quick Reference Guide

Healthy Start & the Prenatal Risk Screen

WHO: **ALL** pregnant women

WHAT: Complete a Prenatal Risk Screening Form

WHEN: During her **FIRST** prenatal visit

WHERE: At her prenatal provider's office

WHY: To determine risk for having a preterm birth or low birth weight baby (leading causes of infant mortality) and make referral to receive services, reduce risks and improve birth outcomes