Maternal Health All Visits Form

*This form should be completed for all clients at all visits*

# Visit Information

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:** |  | | | **Date of Birth:** | |  | | **Due Date:** | |  |
| **Date of Contact:** | |  | **Current Trimester:** | | *1st* *2nd* *3rd* *PP* | | **Place of Service:** | |  | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Service(s) and Duration** | * *96160* ***Medicaid Prenatal Risk Assessment*** | | | |  | | * *H1003* ***Health Education*** | | | |  | | | | * *H0046* ***Psychosocial Services*** | | | |  | |
| *Duration* | | *Duration* | | | | *Duration* | |
|  |  |  | | | | | |  |  |  | | | | | | |  | | |
| * *T1001* ***Nursing Assessment*** |  | | | | | | * *S9123* ***Home Visit by RN*** | | | | | |  | | *-* |  | | | |
| *Duration* | | | | | | *In* | | *Out* |
| ***SBIRT***   * *99408 (15-30)* * *99409 (>30)* |  | | *-* | | | | * *96160-XU –* ***Domestic Violence Screening*** *(additional screening separate from Medicaid Prenatal Risk Assessment but billed on the same day)* | | | | | | | | | | | |  |
| *In* | | *Out* | | | | *Duration* |
| ***Interpretation***   * *T1013* * *T1013 UC* |  | | *-* | | | | * *S9127* ***Social Work Home Visit*** | | | | | |  | | *-* |  | | | |
| *In* | | *Out* | | | | *In* | | *Out* |
|  | | | | |  | | | | | | |  | | | | | | | |
| Services that must be billed separately from Health Education, Psychosocial, or Home Visits: | | | | | | | * *G0444* ***Depression Screening*** | | | |  | | | | * *96160* ***Depression or Domestic Violence Screening*** | | | |  |
| *Duration* | | | | *Duration* |

# All Visit Survey Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Has there been any change in tobacco, alcohol, or illicit drug use?** | | | | | | | | | | | | | | | | | | *Yes* | | | | *No* | | | | *Unknown* |
|  | | | | | | | | | | | | | | | | | | *If yes, describe in narrative* | | | | | | | | |
| **Screening Administered:** | | | * *Domestic Violence* * *Substance Abuse* * *Depression* * *None* | | | | **Referral(s) for support services?** | | | | | * *Domestic Violence* * *Substance Abuse* * *Depression* * *None* | | | | | **Screening tool(s) used:**   * *Abuse Assessment Screen* * *AUDIT* * *DAST* | | | | | | | | * *CRAFFT* * *EPDS* * *PHQ9* * *Other (specify):* | |
| *Note: These screens are not required at every visit, if any screenings are not completed skip sections that are not applicable.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EPDS Score:** |  | **EPDS response to Question #10 is Yes, Quite Often, Sometimes, or Hardly Ever:** | | | | | | | | | | | | *Yes*  *No* | | **If yes, staff response:** | | | | | | | | | | |
|  | | | | |  | | |  | | | | |  |  | | | | | | | | |  | | | |
| **Medicaid Prenatal Risk Assessment Completed?** | | | | | *Yes*  *No* | | | Subtotal A: | | | | |  | **Other risk factors present?** | | | | | | | | | *Yes*  *No* | | | |
| Subtotal B: | | | | |  |
| *Medicaid Prenatal Risk Assessment must be completed at the initial visit. If client is not high risk, they should be rescreened at 28+ weeks in case social risk factors have changed. If high risk, the client does* ***not*** *need to be rescreened and is eligible for all services.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health Education Topics** | | | * *SIDS and Tobacco Use* | | | | | | | | * *Tobacco Cessation Education* | | | | | | | | | * *Seatbelt safety* | | | | * *POST-BIRTH Warning Signs* | | |
| * *Gestational diabetes (for clients with GDM only)* | | | | | | | | * *Nutrition and physical activity* | | | | | | | | | * *Breastfeeding* | | | | * *Safe Sleep* | | |
| **Barriers to education:** | | | | * *Language* | | | | | * *Literacy Level* | | | | | | * *Other:* | | | |  | | | | | | | |
| **Plan of care updated?** | | | | * *Yes* | | * *No* | | | | *Location: (e.g. Signify, paper form, EHR)* | | | | | | | | | | |  | | | | | |

**Narrative Summary:**

*Narrative summary must include a synopsis of the entire visit and all services billed. Include individualized health education notes and client responses, interpretation of any screenings, anticipatory guidance for psychosocial services, and/or a full narrative of a nursing or social worker home visit.*

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| **Provider:** |  | **Signature:** |  | **Date:** |  | |