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:** |  |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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.*

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