

**WEST VIRGINIA
PRENATAL RISK SCREENING INSTRUMENT**

Last Name:		First Name:		MI:	Date of Birth:		Social Security #:								
Street:		City:		State:	Zip Code:	County of Residence:		Telephone:							
								Maiden Name:							
Race: (Check all that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander				U.S. Citizen: ☐ Yes ☐ No		Married: ☐ Yes ☐ No		Insurance Source: ☐ Health Insurance: _____ ☐ No Insurance ☐ Medicaid #: _____							
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino															
Date of 1st Prenatal Visit: (MM/DD/YYYY) Current Weight (lbs) : [][] - [][][] Height (Ft-inches) : [][] - [][][] Blood Pressure: [][][] / [][][]				OBSTETRICAL HISTORY: Gravida [][] Para [][] Term Pre SAB EAB Live LMP: (MM/DD/YYYY): [][] - [][] - [][][][] EDC: (MM/DD/YYYY): [][] - [][] - [][][][] Date of Last Delivery: [][] - [][] - [][][][] Type of Delivery: 1st Trimester: ☐ Miscarriage ☐ Abortion 2nd Trimester: ☐ Miscarriage ☐ Abortion ☐ Preterm Birth ☐ Term Birth				ORAL HEALTH: Sensitive/Bleeding Gums ☐ Yes ☐ No Loose/Broken/Decayed Teeth ☐ Yes ☐ No Dental visit within the last year ☐ Yes ☐ No Dental cleaning in the last year ☐ Yes ☐ No BREASTFEEDING Do you intend to breastfeed? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No							
PREGNANCY RISK FACTORS		Current Preg. Y N		Prior Preg. Y N		Family Hist. Y N		Current Preg. Y N		Prior Preg. Y N		Current Preg. Y N		Prior Preg. Y N	
PROM		na na		☐ ☐		Hypertension		☐ ☐		☐ ☐		Hepatitis C		☐ ☐	
Preterm Delivery		na na		☐ ☐		PIH/Preeclampsia		☐ ☐		☐ ☐		Pyelonephritis		☐ ☐	
Cervical Incompetence		☐ ☐		☐ ☐		IUGR		☐ ☐		☐ ☐		Chromosome Abnormalities		☐ ☐	
Cervical Surgery		☐ ☐		☐ ☐		Low Birth Weight <2500 grams		☐ ☐		☐ ☐		Fetal Anomaly		☐ ☐	
Macrosomia >4000 grams		☐ ☐		☐ ☐		Ectopic Pregnancy		☐ ☐		☐ ☐		Short Cervix		☐ ☐	
Gestational Diabetes		☐ ☐		☐ ☐		Placental Previa		☐ ☐		☐ ☐		Other/Unlisted Risk Factor:			
Previous Stillbirth		na na		☐ ☐		Placental Abruption		☐ ☐		☐ ☐					
Oligohydramnios		☐ ☐		☐ ☐		Previous C-Section		na na		☐ ☐					
Opioid Abuse Treatment		☐ ☐		☐ ☐		Hepatitis B		☐ ☐		☐ ☐					
FAMILY HISTORY:		Current Preg. Y N		Prior Preg. Y N		Family Hist. Y N		MEDICAL CONDITIONS: Yes No On Meds		Yes No On Meds		Yes No On Meds		On Meds	
Multiple Gestation		☐ ☐		☐ ☐		☐ ☐		High Blood Pressure		☐ ☐		Clotting Disorder		☐ ☐	
Fetal Genetic/Structural Abnormalities		☐ ☐		☐ ☐		☐ ☐		Kidney Disease		☐ ☐		STD		☐ ☐	
PSYCHOSOCIAL RISK FACTORS:		Yes No		Yes No		Yes No		Diabetes		☐ ☐		Seizures		☐ ☐	
Disabled		☐ ☐		☐ ☐		☐ ☐		Asthma		☐ ☐		Rh Negative		☐ ☐	
Unemployed/Inadequate Income		☐ ☐		☐ ☐		☐ ☐		Heart Condition		☐ ☐		Other:		☐ ☐	
Husband/Partner Employed		☐ ☐		☐ ☐		☐ ☐		Thyroid Disease		☐ ☐					
Homeless		☐ ☐		☐ ☐		☐ ☐		ENVIRONMENTAL RISK FACTORS:		Yes No		Yes No		On Meds	
Unstable Housing		☐ ☐		☐ ☐		☐ ☐		Lead: House Built before 1978		☐ ☐		☐ ☐		☐ ☐	
Education <12 years		☐ ☐		☐ ☐		☐ ☐		Viral: Cats or Birds in Home		☐ ☐		☐ ☐		☐ ☐	
Currently in Foster Care		☐ ☐		☐ ☐		☐ ☐		Tobacco: 2nd or 3rd Hand Smoke		☐ ☐		☐ ☐			



WV PRENATAL RISK SCREENING INSTRUMENT INSTRUCTIONS

The Prenatal Risk Screening Instrument (PRSI) is intended to promote early and accurate identification of prenatal risk factors. Prenatal Risk Screening Instrument is to be completed by the physician/clinician at the first prenatal visit. If the patient answers "Yes" to any pregnancy or medical risk factor, a Maternal Fetal Medicine consultation should be considered. Data gathered through the PRSI will be used to develop procedures, policy, and obtain funding to address prenatal risk. The goal is to improve birth outcomes for mother and infant. Completion and submission of this form is required by State Law.

General Instructions

Print clearly. Complete the form accurately and completely. When asked to select "Yes" or "No", choose only one option.

Patient Information

Name (List patient's Last Name, First Name & Middle Initial)

Date of Birth (List patient's date of birth as MM/DD/YYYY)

Social Security Number (List patient's social security number; if patient is undocumented or a non-citizen use 000-00-0000)

Address (Use current address where the patient resides)

County of Residence (List the West Virginia County that patient's address is located)

Telephone Number (Use a current telephone number & alternate number, if applicable, where patient can be reached)

Maiden Name (her last name given at birth)

Race/Ethnicity (Check all that apply)

U.S. Citizen (Choose only one option)

Married (Choose only one option)

Insurance Source (Select type of insurance source that patient currently has; if Medicaid, list Medicaid number; private insurance, list insurance company name, ex: PEIA, BCBS)

Entry into Prenatal Care

Date of First Prenatal Visit (Enter the date of the patient's initial medical examination during this pregnancy)

Current Weight (List patient's current weight in pounds)

Height (List patient's current height in feet/inches)

Blood Pressure (List patient's blood pressure reading at time of this visit)

Obstetrical History

Gravida (Enter # of pregnancies in the boxes; include current pregnancy in this number. If Gravida >1, the Para field must be completed.)

Para (This is the # of: Term=Term Deliveries; Pre=Preterm Deliveries; SAB=Spontaneous Abortions; EAB=Elective Terminations; & L=Live Births)

LMP (List date of last menstrual period)

EDC (List estimated date of confinement)

Date of Last Delivery (List patient's last pregnancy delivery date, if applicable)

Type of Delivery (Select type of delivery patient had from last pregnancy, if applicable)

Oral Health

Select "Yes" or "No". If patient answers "Yes" to any of the questions, please consider a referral to a dentist or provide patient education.

Breastfeeding

Select "Yes" or "No" to the questions regarding breastfeeding.

Pregnancy Risk Factors

Select "Yes" or "No" to indicate the presence of risk factors in the patient's current and/or prior pregnancy(ies).

Bleeding During Current Pregnancy

If "Yes", select the trimester(s) that bleeding occurred. Select "No" if bleeding did not occur.

Family History

Select "Yes" or "No" to indicate the presence of risk factors in the patient's current and/or prior pregnancy(ies) and/or whether there is a family history for the selected risk factors.

Medical Conditions

Select "Yes" or "No" to indicate whether the patient currently has the listed medical risk factor and/or is taking medication for the condition.

Psychosocial Risk Factors

Select "Yes" or "No" for each risk factor listed.

Environmental Risk Factors

Indicate by selecting "Yes" or "No" whether the patient has been exposed to listed items in their environment. A patient who lives in a house built before 1978 is at risk for exposure to lead paint.

Reasons for Late Entry into Prenatal Care

Complete this section only when a patient enters prenatal care in the 2nd or 3rd trimester. Fill in "Yes" for all reasons that apply.

Additional Screening Questions

These questions are used as a screening tool to begin discussion about use of drugs, alcohol, tobacco and/or abuse. Advise the patient that the responses she provides are confidential and may only be used for her evaluation and treatment. Any patient who answers "Yes" to one or more questions may warrant further assessment and follow-up.

Provider Information

List name, title, and telephone number of provider completing the PRSI; list date the form was completed. **PLEASE PRINT CLEARLY**

Person Completing Form

List name; Please Print Clearly

Consent

Patient's participation in any referral services is voluntary and her consent must be provided. If patient is interested in further followup/referrals, she must print name, sign and date the form. If patient is not interested in referral services, please leave this section blank.

Completion

Fax the form to (304) 957-0176. Do not include coversheets. Check to be sure the correct side of the form is transmitted.

Fax only one form per patient; do not re-fax a patient's form. Duplicate faxes create problems with processing.

If a payer (MCO, Insurance, etc.) requests the PRSI be faxed to their office, the State Law requires submission to the Office of Maternal, Child and Family Health.

If you have questions, concerns or would like technical assistance to complete the PRSI, please call 304-356-4397.