Gift of Life
Maternity Care Program

Psychosocial Assessment/Case Plan

Date:_____

Risk Status:_____

Patient Name:_____ **Date of Birth**: _____

ASSESSMENT Circle "Y"es or "N"o as appropriate		**NOTES** Description of findings, assessment, etc. using #'s related to the topics
	SOCIAL SUPPORTS	
N Y	1. Good Relationship with Partner	
Y N	2. Domestic Violence	
N Y	3. Good Support System	
N Y	4. Good Relationship with Relatives	
Y N	5. Legal Assistance Needed	
N Y	6. Support Network (church, community center, etc.)	
	ENVIRONMENTAL ISSUES	
N Y	7. Transportation adequate	
Y N	8. Homeless or Soon to be Evicted	
N Y	9. Dwelling Safe and Sanitary	
N Y	10. Home prepared for infant	
N Y	11. Utilities Connected	
Y N	12. Lives Alone	
N Y	13. Assistance with newborn	
N Y	14. Safe sleeping environment for infant	
N Y	15. Car seat for infant	
N Y	16. Adequate Food	
N Y	17. Home /Cell / Message Telephone	
	ECONOMIC STATUS	
N Y	18. Medicaid	
Y N	19. Medicaid application assistance needed	
Y N	20. TPL Exemption Needed	
N Y	21. Employed	
N Y	22. Adequate Income	
Y N	23. Public Benefits Needed	
N Y	24. Child Support (if applicable)	
N Y	25. Establishing Paternity (if applicable)	
	EDUCATIONAL NEEDS	
Y N	26. Limited or Incomplete Education	
Y N	27. History of Special Education/Literacy Barriers	
N Y	28. School Age Children Attending School	
	EMOTIONAL/HEALTHY LIFESTYLES	
N Y	29. Understands Importance of HIV Testing	
N Y	30. Understands/Practices Safer Sex Methods	
Y N	31. Mental Health Problems	
Y N	32. Psychotropic Drugs	
Y N	33. Signs/ Hx of mental illness	
Y N	34. Abused as a child	
Y N	35. Drug, Alcohol Use/Abuse	
Y N	36. Tobacco Use before finding out you were pregnant	
N Y	37. Folic Acid Taken Prior to Pregnancy	
N Y	39. Prenatal Vitamins	
	PREGNANCY ISSUES	
Y N	40. Current Pregnancy Fears/Anxiety	
Y N	41. Previous Postpartum Depression	
Y N	42. Incest or Rape Victim	
N Y	43. Plan 1st Services Received	
N Y	44. Parenting Experience	
N Y	45. Ability to Provide Infant Care	
Y N	46. Children Removed Due to Abuse/Neglect	
N Y	47. Childcare Plan	
N Y	48. Intends to Breastfeed	
Y N	49. Considering Alternative to Pregnancy	
N Y	50. Interest in Childbirth Classes	
	MEDICAL ISSUES/ SPECIAL HEALTH CARE NEEDS	
Y N	51. Complications with Previous Pregnancies	
Y N	52. Diabetes: **Appt. Date W/ Reg. Dietician:**_____	
Y N	53. HIV/AIDS	
Y N	54. Prev. Pre-term Births<37 wks gest.___#live births <37wks gest___	
Y N	55. Date of last pregnancy termed_____	
Y N	56. Genetic Condition	
Y N	57. Hearing impairment	
Y N	58. Sight impairment	
Y N	59. Speech/Language impairment	
N Y	60. Understands medical conditions	
N Y	61. Understands importance of choosing pediatrician	
N Y	62. Understands importance of continuous prenatal care	

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Maternity Care Program

PSYCHOSOCIAL ASSESSMENT/CASE PLAN

Patient Name:_____ Date of Service:_____ Risk Status:_____

PSYCHOSOCIAL ASSESSMENT SUMMARY:

Include identifying information incorporating strengths and weaknesses. List problems/needs.

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……..(Continue on Progress Notes)……..

CASE PLAN:

Develop plan of care to correspond with and address identified problems/needs.

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CC Name:_____Date of Completion_____