

GIFT OF LIFE MATERNITY CARE PROGRAM SERVICE REPORT
Report must be received at the Gift of Life office within 60 days after delivery date

County Code #:	District:	Medicaid #:	Social Security #:	Delivery Date:	Infant #:
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Name: _____ **DOB:** _____
Last First MI MM/DD/YY

Gravida/Para: G P	1st PNV Weight:	Last PNV Weight:	Wks/Days Gestation @ 1st PNV:	Total # PNV:	Date of 1st PNV:	Date of Last preg.:
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Risk Status @ DHCP: @ 1 st PNV <input type="checkbox"/> Low <input type="checkbox"/> High @ Delivery <input type="checkbox"/> Low <input type="checkbox"/> High	Folic Acid, Pre-preg: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Ultrasounds:	Previous Fetal Demise/Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Pre-Term Births 22-37 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Plan 1st Services: Yes No **Pregnancy Planned:** Yes No **Attend Childbirth Classes:** Yes No

Type of Delivery (Circle One) V = Vaginal C = C/Section RC = Repeat C/Section VBAC = Vaginal after C/S AVBAC = Atmpt Vag. After C/S	Type of Anesthesia Given (Circle One) G = General Anesthesia R = Regional Anesthesia L = Local Anesthesia NA = Narcotics O = Other N = None	Pregnancy Outcome (Circle One) LB = Live Birth SB = Stillborn ND = Neonatal Demise Before Discharge	Induced <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: <input type="checkbox"/> Elective <input type="checkbox"/> Fetal Distress <input type="checkbox"/> PROM <input type="checkbox"/> Toxemia <input type="checkbox"/> Other
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Maternal Death: Yes No Date: _____

Medical Risk Factors Present: Yes No *(Circle all that apply)*

STD = Sexually Transmitted Disease	UTI = Urinary Tract Infection	AN = Anemia	MI = Mental Illness
PE = Pre-eclampsia/eclampsia	PTL = Pre-Term Labor	AST = Asthma	RH = RH Negative
AP = Abnormal Pap Smear	ROM = PROM/PPROM	GBS = Group B Strep	HA = HIV/AIDS
PC = Placental Comp/Abruption	MP = Multiple Pregnancy	HYP = Hypertension	MB = Obesity
GC = Genetic Counseling	DV = Domestic Violence	AMA = Adv Mat Age	PV = Prev. Preg. Comp.
	DV Referral Given <input type="checkbox"/> Yes <input type="checkbox"/> No	O = Other: List: _____	

TA = Tobacco Use-**Status at PPV** YES NO UNKNOWN
 No Chg Reduce Del.Quit PPV Quit Unknown

Diabetes Status: ID GD Not diabetic
 - Pt diabetic, counseling & documentation - Date: _____
 - Pt diabetic, no counseling or documentation

Sex of Infant: _____ M = Male F = Female U = Unknown	Weight: (Pounds)	Weight: (Ounces)	Wks/Days Gestation at Del.: _____	Did Infant Go to NICU? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Birth/Infant Complications Present: Yes No *If Yes, circle all that apply*

CA = Congenital Anomalies	FP = Failure to Progress	AH = Abnormal Fetal Heart Rate/Tone
NC = Nuchal Cord	CP = Cephalopelvic Disorder	MP = Malpresentation (breech, compound, etc.)
MS = Meconium/Stain	DE = Delivery (21-34 weeks)	LG = Large for Gestational Age
RD = Respiratory Distress	FD = Fetal Distress	O = Other: List: _____

Delivering Provider Name: _____	Delivering Hospital: _____	Risk Status @ C.C. @ Enrollment: <input type="checkbox"/> Low <input type="checkbox"/> High @ Delivery: <input type="checkbox"/> Low <input type="checkbox"/> High
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PP and/or FP Visit Completed within 60 days of Del. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select type of visit: <input type="checkbox"/> PP Visit (with or without FP) <input type="checkbox"/> FP only visit If PP Visit, circle what applies: DK = Date Kept: _____ SN = Scheduled/ Not Kept	Date Birth Control Method Chosen: _____ (Circle Method Chosen) CS = Condoms PL = Pills CP = Patch ST = Sterilization IM = Implant VR = Vaginal Ring IN = Injection NO = None/Refused IU = IUD OT = Other-List: _____	Breastfeeding @ Hospital Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Breastfeeding @ PP Visit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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CARE COORDINATOR ACTIVITIES				
Code	Risk Status Upon	Completion of Enc.	Date	Notes/Referrals
U1	L / H	_____	_____	_____
U2	L / H	_____	_____	_____
U3	L / H	_____	_____	_____
U4	L / H	_____	_____	Completed at Hospital <input type="checkbox"/> Yes <input type="checkbox"/> No If "no" circle (Office, Home Visit, Attempted HV, Not Completed)
U5	H	_____	_____	_____

(NOTE: Information reported on this form will be used for financial documentation)