

## COMPREHENSIVE NEEDS ASSESSMENT FOR THE AT RISK PREGNANCY

### PART I - PATIENT

1. Initial Visit (Date)	2. Name	3. SSN	4. Age	5. Branch of Service
6. Home Address				7. Rank / Rate
8. Telephone Number (Work)		9. Telephone Number (Home or Cell)		10. E-Mail Address
11. Command			12. Command Point of Contact (POC)	13. POC Telephone Number
14. Estimated Date of Confinement (EDC) / Infant Date of Birth (DOB)			15. Father's Name (Optional)	

### PART II - CASE MANAGEMENT

1. OB Provider	2. Clinic	3. Telephone Number
4. Primary Care Manager	5. Clinic	6. Primary Care Manager Telephone Number
7. Labor Deck Telephone Number	8. Case Manager	9. Case Manager Telephone Number

### PART III - INSTRUCTIONS

Form to be completed by the Case Manager (Care Coordinator, RN, OB Liaison, OB Case Manager) in a face-to-face discussion with the individual.  
 Place an "X" in the appropriate box for each area:  
 1st, 2nd, 3rd Trimester and Postpartum - Mark if the individual requires additional support resources.  
 Appointment Date: Enter date of appointment.  
 Appointment Kept: Enter date appointment kept.  
 Comment: Enter clarifying statements, observations, specific referrals, etc.

### PART IV - HEALTH CARE SUPPORT NEEDS

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
OB Orientation							
OB Referral Completed							
Nutrition Education							
Genetic Counseling							
Tobacco/Alcohol Counseling							

Initial Visit (Date)	Name	SSN
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**PART IV - HEALTH CARE SUPPORT NEEDS (continued)**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
Assess Exercise Habits							
Option Support Guidance (Adoption, Termination, etc.)							
Medical Review							
Prenatal Vitamins Ordered/Taking							
Edinburgh Depression Score							
Emotional Support:							
-- Psychosocial							
-- Spiritual							
-- Relationship or Social							
Women Infants and Children (WIC) Program							
Breastfeeding Class							
Childbirth Class							
New Born Care Class							
Labor & Delivery Tour							
Assess Living Situation and Home Safety Review							
Stressors and Stress Management							
Lactation Education							

Initial Visit (Date)	Name	SSN
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**PART IV - HEALTH CARE SUPPORT NEEDS (continued)**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
1st Newborn Appointment							
6 Week Check-up Mom							
Birth Control Options							
DEERS/TRICARE Enrollment of infant							

**PART V - SOCIAL SUPPORT NEEDS**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
Fleet and Family Support Services							
Transportation							
Budgeting for Baby							
Housing							
Child Care Planning							
Legal Counseling							
Financial Planning							
Partnership/Relationship Counseling							

Initial Visit (Date)	Name	SSN
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**PART V - SOCIAL SUPPORT NEEDS (continued)**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
Social Work Visit in Hospital							
Lactation Education/ Support							
Child Care							
Exceptional Family Member Program (EFMP)							
Community Outreach Programs							

**PART VI - MILITARY COMMAND SUPPORT NEEDS**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
Letter to Command							
Communication with Command POC							
Pregnancy Exercise							
Appointment Requirements							
Occupational Health Review/Risks							
Family Care Plan							
Housing Support Status							

Initial Visit (Date)	Name	SSN
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**PART VI - MILITARY COMMAND SUPPORT NEEDS (continued)**

	1st & 2nd Trimester	3rd Trimester	Post Partum	Appointment Date	Appointment Kept Date	Comments	Case Manager Name & Initials
Working Hours							
Convalescent Leave							
Breastfeeding Support							

**PART VI - ADDITIONAL COMMENTS**