



**OREGON MATERNITY CASE MANAGEMENT
INITIAL ASSESSMENT**

Client Name	DOB	Age	S M D W
Prenatal Care Provider (If none, referral made <input type="checkbox"/>)	Referral Source:		EDC _____
Prenatal Care began at _____ weeks	_____ Gravida	_____ Term	_____ Preterm _____ SAB _____ TAB _____ Living

<div style="display: flex; justify-content: space-between;"> Problem * No Problem </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">*Requires documentation</div>		<div style="display: flex; justify-content: space-between;"> Problem * No Problem </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">*Requires documentation</div>	
PHYSICAL/DENTAL/MENTAL		ENVIRONMENTAL	
<input type="checkbox"/>	Obstetric History & Experience	<input type="checkbox"/>	Housing & Living Situation
<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Guns (locked & unloaded)
<input type="checkbox"/>	Physical Illness	<input type="checkbox"/>	Phone
<input type="checkbox"/>	Dental Health	<input type="checkbox"/>	Smoke Alarm (installed & working)
<input type="checkbox"/>	Special Needs	<input type="checkbox"/>	Exposure to Lead
PSYCHOSOCIAL/BEHAVIORAL		<input type="checkbox"/>	Exposure to Toxins
<input type="checkbox"/>	Substance Use: Self/Significant Others	<input type="checkbox"/>	Pets in Home
<input type="checkbox"/>	Tobacco Exposure: Active/Passive	NUTRITION	
<input type="checkbox"/>	STD/HIV Risk Assessment	<input type="checkbox"/>	Diet
DEVELOPMENTAL/EDUCATIONAL		<input type="checkbox"/>	Pre-pregnant Weight
<input type="checkbox"/>	Last Grade Completed	<input type="checkbox"/>	Body Image
<input type="checkbox"/>	Literacy	<input type="checkbox"/>	Prenatal Vitamins/Folic Acid
<input type="checkbox"/>	Mental, emotional or physical condition affecting learning	EMOTIONAL/RELATIONSHIPS	
<input type="checkbox"/>	Communication/Special Needs	<input type="checkbox"/>	Domestic Abuse
TRANSPORTATION		<input type="checkbox"/>	History of Sexual Abuse
<input type="checkbox"/>	SELF-ASSESSED STRESS LEVEL <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High	<input type="checkbox"/>	Suicide Ideation/Attempt
<input type="checkbox"/> Meets criteria for High Risk Case Management		<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/> RELEASE OF INFORMATION/Date: _____		<input type="checkbox"/>	Support System
		<input type="checkbox"/>	Self-Esteem
		<input type="checkbox"/>	Father of Baby Involvement

Form Sent To	Referred To: _____
Completed By	NOTES
Agency	
Date	



**OREGON MATERNITY CASE MANAGEMENT
Client Service Plan**

Client Name	DOB	EDC
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Client Strengths

Client Concerns

Case Manager Concerns

DATE	PROBLEM	CLIENT'S GOALS OR PLAN	Outcome		
			Met	Partially Met	Not Met

		PROGRESS TOWARDS GOALS/CASE MANAGER NOTES

Discharge Summary/Plan:

Signature	Printed Name	Agency	Date
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