Comprehensive Perinatal Services Program
COMBINED REASSESSMENT &
INDIVIDUALIZED CARE PLAN (ICP)  SECOND TRIMESTER

Date: _____ / _____ / _____  Wks. Gestation: _____

Abbreviations:  Ecd--educated  Fwd--followed  HE--Health Education  HO--handout  N--Nutrition  P--Psychosocial  STT--Steps to Take  Y--Yes  N--No  N/A--not apply  (Info, F/U, R: See Guidelines)

PSYCHOSOCIAL ASSESSMENT
1. Do you have any questions/concerns about your pregnancy? Y O N Describe: ____________________________
   Current pregnancy complications? Y O N
   Fears about labor/delivery? Y O N
   Fears about infant care/parenting skills? Y O N

2. Have there been any changes in your personal life since your last interview?
   Lifestyle Y O N
   Relationship with FOB Y O N
   Living accommodations Y O N
   Finances Y O N
   Emotional support Y O N
   Feeling overwhelmed Y O N
   Experiencing mood swings Y O N
   Other __________________________________________

3. Are you working? Y O N
   Attending school? Y O N
   Is FOB working? Y O N

4. How are others in your life adjusting to your pregnancy?
   FOB: O Positive O Negative
   Family: O Positive O Negative
   Friends: O Positive O Negative

5. Do you have adequate housing? Y O N
   Transportation Y O N
   Adequate finances Y O N
   Clothing for yourself &/or children Y O N
   Other: __________________________________________

6. Are you preparing/prepared for the baby? Y O N
   Adequate support system Y O N
   Infant clothing and supplies Y O N
   Crib Y O N
   Child care arrangements for siblings Y O N

7. Perinatal substance use? Y O N
   Changes in use? Y O N Describe: ____________________________
   Alcohol
   Street Drugs
   Tobacco
   Prescription drugs

8. Are you experiencing threats or abuse from your partner? Emotional Y O N
   Physical Y O N
   Sexual Y O N

ICP Interventions
1. O Educate to allay fears. ____________________________
   O Encourage class attendance-childbirth prep, and infant care/parenting. ____________________________
   O Encourage client to discuss concerns re: complications with medical provider. ____________________________
   O ____________________________________________

   O Fwd STT P 28-34 Financial Concerns
   O Referral: ____________________________________________

   O Fwd STT P 87 Teen Preg. & Parenting: Educ. Plans
   O Referral: ____________________________________________

   O Referral: Housing referral: ____________________________
   O Discussed public transportation. ____________________________
   O Referral: ____________________________________________

   O Fwd STT HE 87 Drug & Alcohol Use, The Risks
   O Fwd STT P 65-68 Perinatal Substance Abuse
   O Ecd per STT P HO-G, H ____________________________
   O Ecd per STT HE HO-R ____________________________
   O Fwd STT HE 83 Secondhand Tobacco Smoke
   O Fwd STT HE 79 Tobacco Use__________________________
   O Ecd per STT HE HO-Q ____________________________
   O Ecd per STT P HO-G ____________________________
   O Reassess each visit. ____________________________
   O Fwd STT P 53-59 Spousal/Partner Abuse
   O Ecd per P HO-E, F ____________________________
   O Referral: ____________________________________________
Psychosocial Problems/Needs  Plan (Developed in consultation with the patient.)

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**NUTRITION ASSESSMENT**

9. Any change in your eating habits? **Y** **N**..............
   Do you have enough food to eat? **Y** **N**
   Enrolled in WIC? **Y** **N** **Declined**

9. Referred to food assistance:
   **Ref** WIC:
   **Ref** RD:

10. 24 Hour Diet Recall obtained below. **Y** **N**........

10. **Fwd** STT N 21-28 *Eating... Food Intake & Recall ............

   **Ecd** Daily Food Guide, WIC or STT N 28

   **Ecd**

**ICP Interventions**

**24 Hour Diet Recall**

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<thead>
<tr>
<th>Time</th>
<th>Amount</th>
<th>Food &amp; Drink</th>
<th>Fruits &amp; Vegetables</th>
<th>Breads, Grains, Cereals</th>
<th>Milk</th>
<th>Protein</th>
<th>Fats Other</th>
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Total

WIC Recommendations

Evaluation

Comments/Nutrition Goals:
Wt. goal: ___ lbs. 
Cumulative wt gain: ___ lbs.

12. BP _____ Change since last visit: O Higher O Lower...
Edema OY ON O Other:

13. Hgb/Hct: Date: ___/___/____
Abnormal blood/urine test results:
Date: ___/___/____
GTT: OY ON Date ___/___/____

14. Are you taking any of the following?..............
Prenatal vitamins OY ON Iron tablets OY ON
Other vitamins/minerals OY ON
Herbs OY ON
New medications OY ON

15. How do you plan to feed your baby?..............
O Breast
O Bottle
O Both

16. Have you been scheduled for tests/procedures?.....
OY ON
Any questions about them? OY ON

17. Have you selected a birth control method?.........
OY ON

18. Do you have a family planning provider? OY ON
19. Do you have a doctor/provider for your baby? ....
OY ON

20. Do you have a car seat for your baby? OY ON......

21. Are you getting enough rest? OY ON ............
22. Are you exercising regularly? OY ON ...........
23. Are you taking any new medications or herbs?....
OY ON

24. Have you attended any prenatal classes? OY ON....

25. What are you interested in learning about?
O Breastfeeding ............................................
O Changes: emotional, physical ..........................
O Circumcision .............................................

**ICP Interventions**

11. O Plotted wt. on grid. O Counseled on wt. gain/loss ....
O Fwd STT N 8-14 **STT to Appropriate Wt. Gain** ..........
O Ecd STT N HO-A, B1, B2 (as appropriate) ...............
O Referral to RD: ..............................................

12. O Notified medical provider. ............................
O Reinforced medical recommendations. ..................
O Reinforced medical recommendations. ..................
O Fwd STT N 59-60 **Anemia** ............................
O Ecd STT N HO-L, M, N ..................................
O Referred to RD: ..............................................

14. Referral: ______________________________________

15. O Fwd STT HE 99-100 **Infant Feeding Decision-Making**
O Fwd STT N 122-131 **Breastfeeding** .................
O Ecd STT N HO-AA, BB1-2, CC1-2, DD1-2, EE1-2
O Breast anatomy & physiology discussed. ............
O Safe formula preparation and storage discussed. ....
O Safe feeding and burping techniques discussed. ....

**Nutrition Problems/Needs**

16. OY ON
17. OY ON
18. OY ON
19. OY ON
20. OY ON

**Nutrition Plan** (Developed in consultation with the patient).

**Health Education Assessment**

16. Have you been scheduled for tests/procedures?.....
OY ON
Any questions about them? OY ON

17. Have you selected a birth control method?.........
OY ON

18. Do you have a family planning provider? OY ON
19. Do you have a doctor/provider for your baby? ....
OY ON

20. Do you have a car seat for your baby? OY ON......

21. Are you getting enough rest? OY ON ............
22. Are you exercising regularly? OY ON ...........
23. Are you taking any new medications or herbs?....
OY ON

24. Have you attended any prenatal classes? OY ON....

25. What are you interested in learning about?
O Breastfeeding ............................................
O Changes: emotional, physical ..........................
O Circumcision .............................................
### Common Discomforts:
- **Constipation**
- **Diarrhea**
- **Fatigue/rest needs**
- **Headaches**
- **Heartburn**
- **Hemorrhoids**
- **Leg cramps**
- **Ligament pain/backache**
- **Nausea/vomiting**
- **Skin changes/striae**
- **Danger signs/emerg. med. care**
- **Dental care**
- **Fetal growth**
- **Fetal movement pattern**
- **Kegel exercises**
- **Labor & delivery**
- **Hospital tour/pre-registration**
- **Parenting skills**
- **Preterm labor education**
- **Rhogam injection (Rh neg.)**
- **SIDS**
- **1 hour GTT**
- **3 hour GTT**
- **Other:**

### ICP Interventions

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### Health Education Problems/Needs

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<th>Plan (Developed in consultation with the patient.)</th>
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### Supervising Physician’s Signature

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