# Healthy Start Prenatal Form | May 2024

OMB Control No. 0915-0338, Expiration Date 09/30/2026

**INFORMATION IN THIS BOX IS FOR GRANTEE RECORDS ONLY—DO NOT UPLOAD**

**Name of Participant: _____** **Date of Birth:_____**

**Name of Interviewer: _____**

**Names and dates of birth are included above for grantee tracking purposes only and should not be submitted to HRSA.**



## GENERAL INSTRUCTIONS

- This prenatal form must be completed with all pregnant participants enrolled in Healthy Start case management/care coordination services.
- This form must be administered by a trained case worker or other Healthy Start grantee staff member to ensure consistency in responses across participants. It should not be self-administered or administered by staff who have not received training.
- Every form should include the participant's Unique ID# (UID) in Question G1. Each person's UID should remain the same across phases and years of participation in the program and should be in the format noted in Question G1.

*See the next page for instructions on completing form updates.*

**When to complete this form**

- **For enrolled case management/care coordination (CM/CC) participants** (a person who is enrolling, or is already enrolled in the program):
    1. Complete this form when a pregnant individual first enrolls in the Healthy Start program.
    2. Complete this form when an enrolled participant becomes pregnant. If the participant has already completed the prenatal form for a prior pregnancy, select "Updated form", "**New pregnancy**" in Question G2, enter the date the form is being completed for the participant's new pregnancy, and screen Questions 1-8 of the Prenatal section for the new pregnancy (ensure the Post-Pregnancy Follow-up section contains no data from the previous pregnancy).

**How to update/re-screen this form**

- **Pregnancy ends** – Update this form and complete the "Post-Pregnancy Follow-up" section when a pregnant participant gives birth, or their pregnancy otherwise ends. To perform a "Pregnancy Ends" update:
    1. Select "Updated form" in Question G2.
    2. Select "Pregnancy Ends" as the reason for update.
    3. Complete "Date of update" field by entering the date the form is being updated.
    4. Complete the "Post-Pregnancy Follow-up" section starting on page 7.
- **Other update to Prenatal section** – update Questions 1-5 if they were unknown at the time of initial screening.
    1. Select "Updated form" in Question G2.
    2. Select "Other update" as the reason for update.
    3. Complete "Date of update" field by entering the date the form is being updated.
    4. Re-screen Questions 1-5 with the participant as needed.
- **Other update to Post-Pregnancy Follow-up section** – update Questions 1-7 of the Post-Pregnancy Follow-up section if they were unknown at the time of initial screening.
    1. Select "Updated form" in Question G2.
    2. Select "Other update" as the reason for update.
    3. Complete "Date of update" field by entering the date the form is being updated.
    4. Re-screen Question 1-7 of the Post-Pregnancy Follow-up section with the participant as needed.

**[GENERAL INFORMATION to be completed by staff:]**

***G1. This individual's Unique ID#:*** _____

[Enter as one number: Grantee Org Code + PP + Client's Unique ID (example: 123PP45678)]

***G2. This form is an…***

*(Select one)*

- ☐ **Initial form** (this is the first time the participant is completing the form)
  ⇨ ***Date of initial form completion:*** _____ *(mm/dd/yyyy)*

- ☐ **Updated form** (the participant has completed this form before and is being screened again)

  **Reason for update** *(Select one)*:

  - ☐ **Pregnancy Ends** (complete the "Post-Pregnancy" section starting on pg. 8)
    ⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*
  - ☐ **Other update**
    ⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*
  - ☐ **New pregnancy** (the participant has completed this form for a prior pregnancy and is completing it again for a new pregnancy)
    ⇨ ***Date of update:*** _____ *(mm/dd/yyyy)*

***(ADMINISTRATIVE)*** *Check the box below if this form is a correction to a version already uploaded to the Healthy Start Monitoring and Evaluation Data System (HSMED). Otherwise, leave this box blank.*

- ☐ This form is a correction.

[Staff – Please read the following statement to the participant:]

***Thank you for participating in the Healthy Start program. The purpose of these forms is to examine how well the Healthy Start program is meeting its goals of helping families improve their health and the health of their babies. This form should take about 15 minutes to complete. Any information you provide will be kept confidential. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.***

## Pregnancy and Health

***For this questionnaire, I'd like to start off by asking you a couple questions about your pregnancy.***

1. ***What is your baby's due date?*** [Staff: If due date is unknown, update this question when it is known.]
   *(Select one)*

   - ☐ **Due Date:** _____ *(mm/dd/yyyy)*
   - ☐ **Don't know**
   - ☐ **Declined to answer**

2. ***How many weeks pregnant are you?*** [Staff: If due date is unknown, update this question when it is known.]
   *(Select one)*

   - ☐ **0 – 13 weeks**
   - ☐ **14 – 27 weeks**
   - ☐ **28 – 40+ weeks**
   - ☐ **Don't know**
   - ☐ **Declined to answer**

3. ***How many weeks pregnant were you when you enrolled in Healthy Start?***
   *(Select one)*

   - ☐ **I enrolled before this pregnancy**
   - ☐ **0 – 13 weeks**
   - ☐ **14 – 27 weeks**
   - ☐ **28 – 40+ weeks**
   - ☐ **Don't know**
   - ☐ **Declined to answer**

4. ***How many weeks pregnant were you when you had your first visit for prenatal care?***
   *(Select one)*

   - ☐ **0 – 13 weeks** [Skip to Q5]
   - ☐ **14 – 27 weeks** [Skip to Q5]
   - ☐ **28 – 40+ weeks** [Skip to Q5]
   - ☐ **I haven't gone for prenatal care yet** [Complete Q4a]
   - ☐ **Don't know** [Skip to Q5]
   - ☐ **Declined to answer** [Skip to Q5]

***4a.*** [Staff: Complete if participant answered, "I haven't gone for prenatal care yet" to Q4] ***Do you have an appointment scheduled?***

*(Select one)*

- ☐ **Yes, my appointment is:** _____ *(mm/dd/yyyy)*
- ☐ **No**
- ☐ **Don't know**
- ☐ **Declined to answer**

***5. Do you know if you are carrying more than one baby (e.g., twins, triplets)?***

*(Select one)*

- ☐ **Yes – How many?** _____ (# of babies)
- ☐ **No, carrying only one**
- ☐ **Don't know**
- ☐ **Declined to answer**

[Staff: If mother has not yet had a prenatal visit and/or does not yet know whether she is pregnant with multiples, update Questions 1 – 5 when she has had a prenatal visit.]

***6. During the <u>3 months before</u> you got pregnant with this child, did you have any of the following health conditions?*** [Staff: For each condition, check "Yes" if participant did have it, or "No" if not.]

| | Health Condition | Yes | No | Don't know | Declined to answer |
|---|---|---|---|---|---|
| a. | Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | | | | |
| b. | High blood pressure or hypertension | | | | |
| c. | Depression or anxiety | | | | |
| d. | HIV/AIDS | | | | |
| e. | Sexually Transmitted Infection (STI/STD) (e.g., gonorrhea, chlamydia, herpes, syphilis) | | | | |
| f. | Obesity | | | | |
| g. | Chronic heart disease | | | | |
| h. | Other chronic condition(s) or illness(es). If "yes", specify all that apply: _____ _____ _____ | | | | |

***7. During your current pregnancy, have you been diagnosed with any of the following conditions?*** [Staff: For each condition, check "Yes" if participant did have it, or "No" if not.]

| | Health Condition | Yes | No | Don't know | Declined to answer |
|---|---|---|---|---|---|
| a. | Gestational diabetes | | | | |
| b. | Gestational hypertension/high blood pressure | | | | |
| c. | Preeclampsia | | | | |
| d. | HIV/AIDS | | | | |
| e. | Sexually Transmitted Infection (STI/STD) (e.g., gonorrhea, chlamydia, herpes, syphilis) | | | | |

## Home Life

***Finally, I have a question about your home life and plans for the baby.***

***8. What method do you plan to use to feed your new baby in the first few weeks*?**

*(Select one)*

- ☐ **Breastfeed only** (includes pumped breast milk*)
- ☐ **Formula feed only**
- ☐ **Both breast* and formula feed**
- ☐ **Don't know yet**
- ☐ **Declined to answer**

## - The Prenatal Form is Complete -

**(Complete the "Post-Pregnancy Follow-Up" on the next page when the participant delivers, or the pregnancy otherwise ends)**

## POST-PREGNANCY FOLLOW-UP

[Staff: Complete this section when the pregnant participant gives birth or the pregnancy otherwise ends; before completing this section, please complete Question G2 by selecting "Updated form" -> "Pregnancy Ends" and entering the date the form is being updated.]

[Staff: Please complete the questions below regarding the outcome of this pregnancy once you have been able to confirm the details.

- **It is important to record the pregnancy outcome for every participant** who was in Healthy Start during the prenatal phase, even if the participant leaves the program.
- **Do not read these questions to the participant.** Instead, determine the outcome in a way that is sensitive to the participant's experiences and record below:]

**1)** [Staff: Record initial outcomes of this pregnancy.]

*(Select all that apply)*

- ☐ **Live birth** – Number of live births from this pregnancy: _____ (# of live births)
- ☐ **Ectopic or tubal pregnancy**
- ☐ **Miscarriage** (pregnancy ended spontaneously before 20 weeks)
- ☐ **Stillbirth or fetal death** (pregnancy ended at 20 weeks or more) – Number of stillbirth or fetal deaths occurred with this pregnancy: _____ (# of stillbirth/fetal deaths)
- ☐ **Termination of pregnancy**
- ☐ **Outcome unknown**

**2)** [Staff: If participant had a live birth, record the type of birth this participant had. If participant did not have a live birth, skip to Question 3.]

*(Select one)*

- ☐ **Vaginal birth** (no forceps or vacuum)
- ☐ **Assisted vaginal birth** (e.g., with forceps or vacuum)
- ☐ **Planned caesarean/c-section birth**
- ☐ **Unplanned caesarean/c-section birth**
- ☐ **Outcome unknown**

**3)** [Staff: Record other outcomes of this pregnancy, labor, and/or delivery that resulted in significant short- or long-term health consequences.]

*(Select all that apply)*

- ☐ **Acute Kidney Failure**
- ☐ **Acute Respiratory Distress Syndrome (ARDS)**
- ☐ **Disseminated Intravascular Coagulation (DIC) - a blood clotting disorder**
- ☐ **Eclampsia**
- ☐ **Hysterectomy**
- ☐ **Pulmonary Edema or Acute Heart Failure**
- ☐ **Sepsis/Infection**
- ☐ **Shock**
- ☐ **Other: _____**
- ☐ **Outcome unknown**
- ☐ **None**

**4)** [Staff: Enter the Unique ID#(s) (ECUID) of the baby/babies from this pregnancy who are now enrolled in Healthy Start.]

[Enter as One Number: Grantee Org Code + EC + Client's Unique ID (e.g., 123EC45678)]

- ☐ **UID for 1st child: _____**
- ☐ **UID for 2nd child: _____**
- ☐ **UID for 3rd child: _____**
- ☐ **UID for 4th child: _____**

***5)*** [Staff: Among the babies who were born alive from this pregnancy, did any pass away before 27 days of life (that is, baby is born alive but dies within 0-27 days of life)?]

*(Select one)*

- ☐ **Yes** – Number of neonatal deaths from this pregnancy: _____ (# of neonatal deaths)
- ☐ **No**
- ☐ **Outcome unknown**

**6)** [Staff: Did this individual die during pregnancy or within one year of the end of the pregnancy due to any cause?]

*(Select one)*

- ☐ **Yes**
- ☐ **No**
- ☐ **Outcome unknown**

**7)** [Staff: What sources of information were used to determine the pregnancy outcomes reported in Questions 1 – 6?]

*(Select all that apply)*

- ☐ **Participant self-report**
- ☐ **Hospital records or medical record**
- ☐ **Vital records**
- ☐ **Other family member or close relative**
- ☐ **Other source, specify:** _____

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**[FOLLOW-UP INSTRUCTIONS - If the outcome of the pregnancy:**

- **Was a <u>healthy participant and baby</u>, complete the Parent/Child Form *as soon as possible* and update the participant's Background Information form.**
- **Was <u>mixed</u> and <u>included both a live baby and a fetal or neonatal death, or a very ill baby or participant</u>, then please be sensitive of the participant's experience and potentially delay completing (e.g., at the next visit) the Parent/Child Form for the live baby or updating the participant's Background Information Form.**
- **<u>Did not include a live birth</u> (e.g., miscarriage, ectopic or tubal pregnancy, fetal death or stillbirth, other pregnancy termination, neonatal death), be sensitive of the participant's experience, and potentially delay updating (e.g., at the next visit) their Background Information Form.]**

## The Post Pregnancy Follow-up Section is Complete