

1. Last name	First name	MI	N.C. Department of Health and Human Services Division of Public Health Women's and Children's Health Section PREGNANCY OUTCOME SUMMARY <i>(See Instructions)</i>			
2. Patient Number						-- H
3. Date of Birth						
			Month	Day	Year	
4. Race <input type="checkbox"/> 1=White <input type="checkbox"/> 2=Black <input type="checkbox"/> 3=American Indian/Alaskan Native (Check all that apply.) <input type="checkbox"/> 4=Asian/Pacific Islander <input type="checkbox"/> 5=Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 6=Unknown Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 3=Unknown						
5. Sex <input checked="" type="checkbox"/> 2=Female			Date of Form Completion			
6. County of Residence			Date Pregnancy Ended or N/A <input type="checkbox"/>			
Medicaid Number			Date of MCCP Closure or N/A <input type="checkbox"/>			
Medicaid Type <input type="checkbox"/> 1=Blue <input type="checkbox"/> 2=Pink (MPW) <input type="checkbox"/> 3=PE only <input type="checkbox"/> 4=None			Month	Day	Year	
Reason for Maternal Health Closure (Use <u>only</u> for women <u>not</u> enrolled in MCCP at closure. Check one.) <input type="checkbox"/> 1=Pregnancy Ended <input type="checkbox"/> 2=Lost to Follow-Up <input type="checkbox"/> 3=Moved <input type="checkbox"/> 4=Maternal Death <input type="checkbox"/> 5=Declined Prenatal Care <input type="checkbox"/> 6=Not Pregnant <input type="checkbox"/> 7=Transferred to Other Provider						
Reason for Maternity Care Coordination Program (MCCP) Closure (Check one.) <input type="checkbox"/> 1=Pregnancy Ended <input type="checkbox"/> 2=Lost to Follow-Up <input type="checkbox"/> 3=Moved <input type="checkbox"/> 4=Maternal Death <input type="checkbox"/> 5=Declined MCC Services <input type="checkbox"/> 6=Services No Longer Needed <input type="checkbox"/> 7=Transferred to Other Provider <input type="checkbox"/> 8=Incarcerated <input type="checkbox"/> 9=No Longer Medicaid-Eligible						
Multiple births or outcomes <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No						
Prenatal Care Provider <input type="checkbox"/> 1=Health Department <input type="checkbox"/> 2=Private Provider <input type="checkbox"/> 3=Rural/Community Health Center <input type="checkbox"/> 4=Tertiary High Risk Center (Check <u>all</u> that apply.) <input type="checkbox"/> 5=None						
Maternal Data <i>Enter maternal data for all pregnancy outcomes.</i> __ __ Number of weeks gestation when prenatal care began <i>(Enter 99 if no prenatal care received.)</i> __ __ Total number of prenatal visits regardless of medical provider __ __ __ lbs. Pre-pregnancy weight __ feet __ __ inches Height without shoes __ __. __ Pre-pregnancy Body Mass Index (BMI) __ __ __ lbs. Weight at last prenatal visit prior to delivery __ __ Total prenatal weight gain						
			BMI = $\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \times 703$			
Referred for WIC prenatally? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No Received WIC prenatally? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 4=Declined <input type="checkbox"/> 5=Ineligible Received WIC postpartum? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 4=Declined <input type="checkbox"/> 5=Ineligible Received postpartum exam/family planning exam? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 6=Lost to Follow-up Received method of family planning? <input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No <input type="checkbox"/> 3=Unknown						

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Maternity Care Coordination Information

Client received Maternity Care Coordination Program (MCCP) services? *(If answer is No, Declined, Not Eligible, or Not Available, proceed to Infant Data.)*

- 1=Yes 2=No 3=Declined 4=Not Eligible 5=Not Available

Maternity Care Coordinator Staffing Qualification

- 1=Registered Nurse 2=Social Worker with social work degree 3=Social Worker with other degree

Client received Maternal Outreach Worker (MOW) services?

- 1=Yes 2=No 3=Declined 4=Not Eligible 5=Not Available

__ __ Weeks gestation when MCCP services began. *(Enter 99 if MCC services began postpartum.)*

__ __ Number of months client received MCCP services.

__ __ __ Number of total units of MCCP services client received.

Medical Risks Identified Since Screening (for Maternity Care Coordination Program recipients only)

Mark the appropriate code to indicate medical risk factors identified since MCCP intake screening.

- | | |
|--|---|
| <input type="checkbox"/> Ectopic or molar pregnancy (current pregnancy)
<input type="checkbox"/> Pregnancy with congenital anomaly (current pregnancy)
<input type="checkbox"/> Obstetrical problems (current pregnancy)
<input type="checkbox"/> Multiple pregnancy (current pregnancy)
<input type="checkbox"/> Uterine or cervical abnormalities
<input type="checkbox"/> Vaginal bleeding (current pregnancy)
<input type="checkbox"/> Recurring UTIs/STIs/Vaginal infections
<input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Gestational diabetes
<input type="checkbox"/> Anemia or sickle cell disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart, kidney, or lung problems
<input type="checkbox"/> Prescription medication
<input type="checkbox"/> Late entry to prenatal care (after 1 st trimester) |
|--|---|

Psychosocial Risks/Needs Outcomes (for Maternity Care Coordination Program recipients only)

Mark the appropriate code to indicate the outcome of the needs identified during MCCP services.

- Codes: ① = Need addressed and resolved
 ② = Need addressed and ongoing
 ③ = Need not met, insufficient resources
 ④ = Need not met, client declined services

- | | |
|--|---|
| ①②③④
<input type="checkbox"/> Medicaid Participation
<input type="checkbox"/> Adequate Prenatal Care
<input type="checkbox"/> Medical Home for Self or Family
<input type="checkbox"/> Family Planning
<input type="checkbox"/> Interpreter Services
<input type="checkbox"/> Support System
<input type="checkbox"/> Transportation
<input type="checkbox"/> Employment
<input type="checkbox"/> School Enrollment or GED
<input type="checkbox"/> Child Care
<input type="checkbox"/> Financial Resources | ①②③④
<input type="checkbox"/> Nutritional Counseling
<input type="checkbox"/> Food Assistance
<input type="checkbox"/> Breastfeeding/Infant Feeding
<input type="checkbox"/> Parenting Information
<input type="checkbox"/> Adequate or Safe Housing
<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Substance Use
<input type="checkbox"/> Mental Health or Behavioral Health
<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> _____
<div style="text-align: right; font-size: small;"><i>Local Use/Demonstration</i></div> |
|--|---|

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Infant Data
Baby A

Pregnancy Outcome <i>If live birth, complete additional fields.</i>	<input type="checkbox"/> 1=Live Birth <input type="checkbox"/> 2=Spontaneous Abortion <input type="checkbox"/> 3=Therapeutic Abortion <input type="checkbox"/> 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz or g
Sex	<input type="checkbox"/> 1=Male <input type="checkbox"/> 2=Female
Mother Breastfeeding?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Baby receiving WIC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Health Check Exam or Well Child Care?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Referred to CSC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No

Baby B

Pregnancy Outcome <i>If live birth, complete additional fields.</i>	<input type="checkbox"/> 1=Live Birth <input type="checkbox"/> 2=Spontaneous Abortion <input type="checkbox"/> 3=Therapeutic Abortion <input type="checkbox"/> 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz or g
Sex	<input type="checkbox"/> 1= Male <input type="checkbox"/> 2= Female
Mother Breastfeeding?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Baby receiving WIC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Health Check Exam or Well Child Care?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Referred to CSC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No

Baby C

Pregnancy Outcome <i>If live birth, complete additional fields.</i>	<input type="checkbox"/> 1=Live Birth <input type="checkbox"/> 2=Spontaneous Abortion <input type="checkbox"/> 3=Therapeutic Abortion <input type="checkbox"/> 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz or g
Sex	<input type="checkbox"/> 1= Male <input type="checkbox"/> 2= Female
Mother Breastfeeding?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Baby receiving WIC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Health Check Exam or Well Child Care?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No
Referred to CSC?	<input type="checkbox"/> 1=Yes <input type="checkbox"/> 2=No

Name(s) and signature(s) of person(s) completing form:

Print name: _____

Signature: _____ Date: ____/____/____

Print name: _____

Signature: _____ Date: ____/____/____

Instructions for the Pregnancy Outcome Summary (POS)

Purpose:

To collect data on pregnancy outcomes for Maternal Health patients and/or Maternity Care Coordination Program clients. All Maternal Health patients and Maternity Care Coordination Program clients must have the POS completed within 30 days of discontinuation of services and submitted through the Health Services Information System (HSIS).

Preparation:

- 1. Complete form, entering all required data.*
- 2. Submit data into HSIS.*
- 3. File original form in client's medical record.*

Disposition:

This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Historical Resources.

Additional forms may be ordered using the Requisition for Maternal Health Materials form (DHHS 3980), available at <http://wch.dhhs.state.nc.us/whs.htm>.