SAMPLE

OB/CPSP - Required Documentation Check List

May place one in each OB Record to remind you of the required items during your Medical Record Audit
**** OB charts must also be reviewed using the pediatric or adult preventive criteria.**

Patient Name: _____ **Date:** _____

Allergies: _____ ☐ NKA **Reactions to Allergies**: _____

Emergency Contact #_____ **Name:** _____

Primary Language: _____ **Interpreter required?** ☐ Yes ☐ No

Person/ Entity providing medical Interpretation: _____

Advance Health Care Directive offered: ☐ Yes ☐ No ☐ Refused **Date:** _____

Signed Copy of the Notice of Privacy: ☐ Yes ☐ No **Consent for treatment:** Yes ☐ No ☐

Release of Medical Records: ☐ Yes ☐ No **Informed Consent for invasive procedures:** Yes ☐ No ☐

Last History and Physical: _____ **Date last age specific SHA form completed:** _____
(every 1-5 years, pending physician judgement) (**SHA *reviewed annually, dated and signed***).

Initial Comprehensive Prenatal Assessment:

Initial Prenatal Visit: _____ **Obstetrical & Medical History:** ☐ Yes ☐ No
Physical Exam: ☐ Yes ☐ No **Dental Assessment:** ☐ Yes ☐ No

Lab Tests: **Bacteriuria Screening** *(at 12-16 wks gestation or after 1st prenatal visit):* ☐ Yes ☐ No
RH Incompatibility Screening *(24-28wks):* ☐ Yes ☐ No **Diabetes Screening:** ☐ Yes ☐ No
(at 24 weeks)
Hepatitis B Virus Screening: ☐ Yes ☐ No **Chlamydia Infection Screening:** ☐ Yes ☐ No
Syphilis Infection Screening: ☐ Yes ☐ No **Gonorrhea Infection Screening:** ☐ Yes ☐ No

First Trimester Comprehensive Assessment
Individualized Care Plan (ICP): ☐ Yes ☐ No **Nutrition:** ☐ Yes ☐ No
Psychosocial: a) Maternal Mental Health Screening_____ **b) Social Needs Assessment**_____
c) Substance Use/ Abuse Assessment_____
Health Education *(breast feeding, language, cultural competence & education needs)* ☐ Yes ☐ No
Preeclampsia Screening: ☐ Yes ☐ No **Intimate Partner Violence Screening:** ☐ Yes ☐ No

Second Trimester Comprehensive Re-Assessment

Individualized Care Plan (ICP): ☐ Yes ☐ No **Nutrition:** ☐ Yes ☐ No

Psychosocial: a) Maternal Mental Health Screening_____ b) Social Needs Assessment_____
c) Substance Use/ Abuse Assessment_____

Health Education *(breast feeding, language, cultural competence & education needs)* ☐ Yes ☐ No

Preeclampsia Screening: ☐ Yes ☐ No **Intimate Partner Violence Screening:** ☐ Yes ☐ No

Third Trimester Comprehensive Re-assessment

Individualized Care Plan (ICP): ☐ Yes ☐ No **Nutrition:** ☐ Yes ☐ No

Psychosocial: a) Maternal Mental Health Screening_____ b) Social Needs Assessment_____
c) Substance Use/ Abuse Assessment_____

Health Education *(breast feeding, language, cultural competence & education needs)* ☐ Yes ☐ No

Preeclampsia Screening: ☐ Yes ☐ No **Intimate Partner Violence Screening:** ☐ Yes ☐ No

Screening for Strep B *(Between 35-37 wks)* ☐ Yes ☐ No **Tdap Immunization** ☐ Yes ☐ No

Prenatal care Visit periodicity according to most recent ACOG standards

First visit by 6th-8th week ☐ Yes ☐ No

Approximately every 4 weeks for the 1st 28 weeks of pregnancy ☐ Yes ☐ No

Every 2-3 weeks until 36 weeks ☐ Yes ☐ No

Weekly thereafter until delivery ☐ Yes ☐ No

Postpartum visit within 3 weeks after delivery concluding 4-12 weeks after delivery: ☐ Yes ☐ No

Influenza Vaccine: _____ (*any trimester during their pregnancy)*

Referral to WIC & assessment of Infant Feeding status ☐ **Yes** ☐ **No**

HIV-related services offered ☐ **Yes** ☐ **No**

AFP/Genetic Screening offered *(prior to 20 weeks gestation)* ☐ Yes ☐ No

Family Planning Evaluation ☐ **Yes** ☐ **No**

Comprehensive Postpartum Assessment

Individualized Care Plan (ICP): ☐ Yes ☐ No **Nutrition:** ☐ Yes ☐ No

Psychosocial: a) Maternal Mental Health Screening_____ b) Social Needs Assessment_____
c) Substance Use/ Abuse Assessment_____

Health Education *(breast feeding, language, cultural competence & education needs)* ☐ Yes ☐ No

Comprehensive Physical Exam *(within the 1st 3 weeks postpartum):* _____