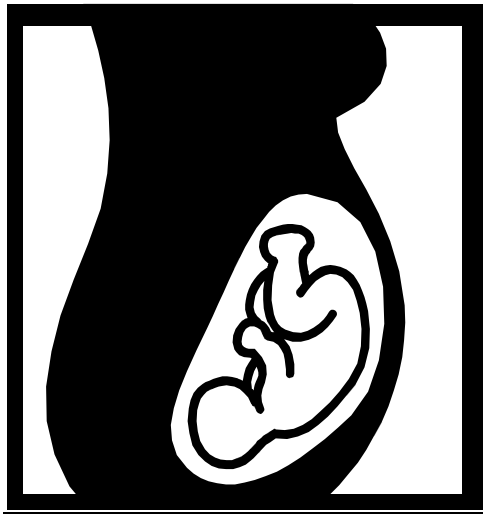
Winn Army Community Hospital

Department of Obstetrics

OB REGISTRATION PACKET



Please complete all forms and bring them to your initial OB appointment.

Winn Army Community Hospital Appointment

Line: (912) 435-6633, Option 1 & 2

The Women's Health Center

The staff of the Women's Health Center would like to welcome you to our Center and congratulate you on your pregnancy. It is a privilege to provide care for you during one of the most exciting times of your life. Let us take an opportunity to tell you about our department.

The Center consists of both an Obstetric and Gynecology Service. The Obstetric Service consists of a "Provider Team" concept which allows you access to a team of providers consisting of a Physician, Certified Nurse Midwife and a Certified Advanced Nurse Practitioner. Upon completion of your initial OB Interview appointment, you will be assigned to a team. At times when your preferred provider is not available, a member of your team will continue your care. At the time of delivery, the Healthcare Provider on call will care for you and your baby.

The Center is open from 0730 – 1630 Monday – Friday (except for federal and training holidays). Patients are also seen at Tuttle Clinic on Tuesdays from 0800 – 1630.

If you are station at HAAF or live in the Savannah area, please schedule your OB Interview at Tuttle Clinic.

At your OB Interview you should have received two cards; one with Important Telephone Numbers and one with the number and names of your team members. If you did not receive these cards, please ask for them at your next appointment.

If you are acutely sick or have pregnancy related concerns you may access care by calling our OB Triage Nurse to be evaluated. Simply call 435-6633 or 1-800-652-9221 Monday – Friday 0730 – 1600 and leave a message with the receptionist.

Our Triage Nurse will return your call and talk with you about your needs. She will answer any questions you may have, advise you about self care, or schedule an appointment if needed. The Acute Care Clinic is closed on 4th Thursday each month for training, but don't let that keep you from calling. We are always available to address your needs.

It is very important to keep you informed and educated during your pregnancy. Your copy of the book "Pregnancy and Childbirth" is available for you to access online at www.winn.amedd.army.mil . Select Medical Services and then Women's Health. Please READ and refer to the book throughout your pregnancy. The department offers classes to assist you in your pregnancy education needs. You can view the classes at the website listed and then call the OB clinic for class registration.

Again, welcome to the Women's Health Center. If you have any questions or needs, we will be happy to assist you at any time.

The OB/GYN Staff

OB Registration Checklist

In order to expedite your registration, please use this checklist as a guide to ensure successful completion of all steps.

- **Download, print, complete and sign OB registration forms.**

- __ Medical Record- Antepartum Prenatal Social Needs and Nutrition Assessment (form#1223)
- __ Medical Record- Antepartum Patient Questionnaire (form#1222)
- __ Medical Record- Consent form Cystic Fibrosis Carrier Test (form#1224)
- __ Sequential Screen for Down Syndrome, Trisomy 18, and Open Neural Tube Defects (form#1429)
- __ New Parent Support Program Registration form
- __ Privacy Act Statement-Health Care Records (formDD2005)
- __ Acknowledgement of Receipt of Winn ACH Notice of Privacy Practice (form1424)
- __ Register for the "Weekly Parent Review" and print form; click on link at this same website
- __My OB Interview/registration appointment date is: _____; please bring all forms with you.

OB Registration Checklist

In order to expedite your registration, please use this checklist as a guide to ensure successful completion of all steps.

Please review the following patient education information before completing forms.

- __ "The Women's Health Center" Welcome Letter
- __ Cystic Fibrosis patient education information at the following website http://www.acog.org/publications/patient_education/bp171.cfm
- __ Sequential Screening patient education video at the following website www.ntqr.org and select patient education video located in upper right hand corner

MEDICAL RECORD - ANTEPARTUM PATIENT QUESTIONNAIRE

Date of Visit: _____

Self-Administered Questionnaire - First Visit (To Be Completed by Patient)

SECTION I - Domestic Abuse	***Yes**	**No**	**Unk**
1. Within the last year, have you been hit, slapped, or kicked?			
2. Since you learned that you are pregnant, have you been hit, slapped, or kicked?			
3. Within the last year have you been forced to participate in sexual activity?			
4. Do you live with anyone who hits you or hurts you in any way?			
SECTION II - Immediate Concerns			
5. Are you having pain? Scale 0 - 10 Location:: _____ Intensity: _____ (0 = no pain - 10 = worst pain)			
6. Do you have a history of ectopic pregnancy?			
7. Do you have a history of any severe pelvic infections requiring hospitalization?			
8. Do you have a history of pelvic surgery for either infertility or infection?			
9. Do you have any chronic medical conditions that requires medication?			
SECTION III - Infections			
10. Do you currently have or have you ever had or been exposed to tuberculosis?			
Have you ever lived with anyone who had tuberculosis?			
11. Do you currently have or have you ever had or been exposed to any suxually transmitted diseased including chlamydia, herpes, honorrhea, syphilis, venereal warts, HPV or HIV?			
12. Do you currently have or have you ever had kidney or bladder problems, urinary tract infection or systitis?			
13. Do you currently have or have you ever had or been exposed to hepatitis?			
14. Have you had a rash or viral illness since your last menstrual period?			
15. Were you stationed overseas?			
16. Were you born outside of the United States?			
17. Do you live in a house with cats?			
SECTION IV - Medical History			
18. Do you currently have or have you ever had an ulcer, stomach problems, or colitis?			
19. Do you currently have or have you ever had an abnormal Pap smear or female or gynecological problems?			
20. Have you ever had infertility problems?			
21. Do you currently have or have you ever had heart disease?			
22. Do you currently have or have you ever had rheumatic disease?			
23. Do you currently have or have you ever had high blood pressure?			
24. Do you currently have or have you ever had pneumonia or asthma?			
25. Do you currently have or have you ever had epilepsy or seizures?			
26. Do you currently have or have you ever had emotional problems?			
27. Do you currently have or have you ever had thyroid problems?			
28. Do you currently have or have you ever had diabetes?			
29. Do you currently have or have you ever had varicose veins or blood clots in your legs?			
30. Are you currently in need of or have you ever had an operation?			
31. Do you currently have or have you ever had broken bones or a concussion?			
32. Have you ever had blood transfusions?			
33. Do you currently have or have you ever had lupus or other autoimmune diseases?			
34. Are you allergic to any medications?			

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

*Please explain any "Yes" responses:

SECTION V - Family Health History	*Yes	No	Unk
35. Have you, the baby's father, or anyone in either of your families ever had any of the following:			
a. Multiple births			
b. Lupus or autoimmune disease			
c. Down syndrome (mongolism)			
d. Neural tube defect (for example: spina bifida or meningomeyelocele)			
e. A baby born with anencephaly (without a brain or skull)			
f. Hemophilia or other bleeding disorders			
g. Muscular dystrophy			
h. Cystic fibrosis			
i. Sickle cell disease			
j. Mental retardation			
k. Any other chromosomal abnormality or birth defect not listed?			
SECTION VI - Social & Lifestyle History			
36. Do you ever drive or ride in a car without wearing seat belts?			
37. Do you use tobacco?			
a. Do you want to quit?			
b. Have tobacco cessation materials been offered to you?			
38. Do you use alcohol?			
Have much? _____ Type: _____			
39. Have you ever used street drugs such as marijuana, LSD, speed, heroin, crystal, crack, cocaine, ecstasy, etc.?			
40. Have you taken any medications since becoming pregnant (include all prescription and nonprescription drugs?			
41. Over the last two weeks have you felt: ☐ Down, depressed or hopeless? ☐ Little interest or pleasure in doing things?			
42. What is the highest level of education you have completed? _____			
43. Are you a vegetarian?			
44. Do you have an eating disorder such as bulimia or anorexia?			
45. What is your occupation? _____			
46. Since becoming pregnant, have you been exposed to x-rays to toxic chemicals?			
47. What is your primary language? _____			
48. What is your religion? _____			
SECTION VII - Menstrual History			
49. When was the first day of your last normal menstrual period? _____			
50. Are your periods usually irregular?			
How long do your periods last? _____			
51. What type of birth control, if any, did you last use? _____ When? _____			
SECTION VIII - Pregnancy History			
52. How many previous pregnancies have you had? _____			
53. How many live births have you had? _____			
54. Is this an unplanned pregnancy?			

* Please explain any "Yes" responses

Patient's Signature / Date

Provider's Signature / Date

MEDICAL RECORD - ANTEPARTUM PRENATAL SOCIAL NEEDS AND NUTRITION ASSESSMENT

Please answer the following questions. The information you provide will help us better plan your care. If you need help with the completion of this form, please ask any member of the staff.

SECTION I - PRENATAL SOCIAL NEEDS ASSESSMENT (To be Completed by Patient)

1. Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
2. I live with my: ☐ Husband ☐ Boyfriend ☐ Parents ☐ Roomate ☐ By myself
3. Will your significant other be deployed during your pregnancy? ☐ Yes ☐ No
4. Will you be moving from this area during your pregnancy? ☐ Yes ☐ No
5. I live in: ☐ Base Housing ☐ Home ☐ Apartment ☐ BEQ/BOQ ☐ Other fy)_____
6. I am happy with my living accommodations: ☐ Yes ☐ No
7. I have lived in the current area for: ☐ Less than a month ☐ 1-6 months ☐ 7 - 12 months ☐ Over a year
8. I have supportive family / friends in this local area: ☐ Yes ☐ No
9. My partner is supportive of this pregnancy: ☐ Very Supportive ☐ Somewhat supportive ☐ Not Supportive
10. My primary means of transportation is: ☐ Own car ☐ My partner ☐ Friend's car ☐ Public transportation ☐ Other (please specify): _____
11. My current financial status is: ☐ Good ☐ Fair ☐ Poor
12. If this pregnancy was unplanned, what options have you thought about? ☐ Keeping the child ☐ Adoption ☐ Abortion ☐ Foster placement
13. This is my first pregnancy: ☐ Yes ☐ No
14. How many children live with you? _____ Children's Ages: _____
15. What is your biggest concern right now?

How are you adjusting / dealing with this concern?

16. You can help us help you by sharing your concerns. Please check any of the following areas in which you might need information / assistance:

- ☐ Money
- ☐ Babysitting
- ☐ Career Help
- ☐ Counseling
- ☐ Family Planning
- ☐ Goal Setting
- ☐ Housing
- ☐ Items for Baby
- ☐ Legal Assistance
- ☐ Food
- ☐ Parenting Classes
- ☐ Safety Issues
- ☐ Transportation
- ☐ Other (please list) _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

SECTION II - PRENATAL NUTRITION QUESTIONNAIRE (To be Completed by Patient)

Your nutrition can have an important effect on your baby's health. Please answer these questions by checking the answers that apply to you.

Part A - EATING BAHAVIOR

17. Are you frequently bothered by any of the following? (Check all that apply)

18. Do you skip meals at least 3 times a week? ☐ Yes ☐ No

19. Do you try to limit the amount or kind of food you eat to control your weight? ☐ Yes ☐ No

20. Are you on a special diet now? ☐ Yes ☐ No If yes, what _____

21. Do you avoid any foods for health or religious reasons? ☐ Yes ☐ No

Part B - FOOD RESOURCES

22. Do you have a working stove? ☐ Yes ☐ No

23. Do you have a refrigerator? ☐ Yes ☐ No

24. Do you sometimes run out of food before you are able to buy more? ☐ Yes ☐ No

25. Can you afford to eat the way you should? ☐ Yes ☐ No

26. Are you receiving any food assistance now? **(Check all that apply)**

☐ Donated food / commodities ☐ School breakfast ☐ School lunch ☐ WIC ☐ CSFP

☐ Food Stamps ☐ Food pantry ☐ Soup kitchen ☐ Food bank

☐ Yes ☐ No

Part C - FOOD and DRINK

28. What did you drink yesterday?

Beverage	Amount

29. What did you eat yesterday?

Food	Amount

30. Were any of these whole grains? ☐ Yes ☐ No

31. Is the way you ate yesterday the way you usually eat? ☐ Yes ☐ No

Patient's Signature / Date

Provider's Signature / Date

MEDICAL RECORD - CONSENT FORM
CYSTIC FIBROSIS CARRIER TEST

I understand that I am being asked to decide whether or not to have the Cystic Fibrosis test that identifies someone who is a carrier of this disease. By signing below, I show that I have been told what the test can and cannot do and that my questions were answered to my satisfaction.

By signing below I understand that:

1. This test can tell if I am a carrier of cystic fibrosis (CF), which means I have the gene but not the disease,
2. The risk of being a CF carrier depends on my race:
    a. European Caucasian, Ashkenazi Jew
        1. chance of 1 in 29 one parent is a carrier
        2. chance of 1 in 841 both parents are carriers
    b. Hispanic American
        1. chance of 1 in 46 one parent is a carrier
        2. chance of 1 in 2,116 both parents are carriers
    c. African Americans
        1. chance of 1 in 65 one parent is a carrier
        2. chance of 1 in 4,225 both parents are carriers
    d. Asian American
        1. chance of 1 in 80 one parent is a carrier
        2. chance of 1 in 8,100 both parents are carriers
3. I am the one to decide whether or not I am tested.
4. The test is not perfect. Some carriers are missed by the test.
5. If I am a carrier, in order to have a better idea of my baby's chances of getting the disease, testing the baby's father is needed.
6. If both parents are carriers, my baby has 1 in 4 chance of having CF. In that case, I will have the chance to have more testing to tell whether my baby has the disease.
7. If my baby has the CF gene from both parents, ending my pregnancy is the only way to avoid having a baby with Cystic Fibrosis.
8. Some individuals have not been able to get insurance because of the test results. I understand that my military health coverage will not be changed.

It is also important to know that Cystic Fibrosis testing, like any DNA testing, can show that someone is not the real father. If the person who is thought to be the father has a negative test, but the baby turns out to have the disease after birth, then it would be suspected that the real father is someone else. Possibly, other unknown family information may be uncovered.

I (circle one) would or would not like to have the Cystic Fibrosis Carrier test.

Patient: _____ _____
(Print Name) (Date)

_____
(Signature)

Witness: _____ _____
(Print Name) (Date)

_____
(Signature)

Family Advocacy

NEW PARENT SUPPORT PROGRAM

Request for Home Visitor Services

Requested by_____ Date of Request_____

Agency/Requester Phone#_____ Do you want a follow-up contact? _____

1. Referral for:

Name (last, first) _____

Soldier/Family Member/Other Marital Status_____ Years Married_____

Date of Birth_____/_____/ _____ Female/Male SSN_____-_____-_____

Address_____

Phone_____ Rank_____

Deployment Status_____ Unit_____

2. Name of Spouse/Sponsor:

Name (last, first) _____

Soldier/Family Member/Other Marital Status_____ Years Married_____

Date of Birth_____/_____/ _____ Female/Male SSN_____-_____-_____

Address_____

Phone_____ Rank_____

Deployment Status_____ Unit_____

Is there a member of this family who is pregnant? Yes / no Due date: _____

Please note reason for referral and list children on the back of this form.

PRIVACY ACT STATEMENT

PRINCIPAL: To collect data necessary to enroll DOD personnel and their family members in the Army Community Service client database. Also used as a tool to aid in delivery of services to DOD personnel and their family members. Statistical data will be provided to Department of the Army.

ROUTINE USES: The information you provide will be used to establish your ACS client record. Used as a record of (1) services requested, (2) services delivered, and (3) actions or services agreed upon. Upon entry, form will be filed.

DISCLOSURE: Disclosure of information is voluntary. Failure to provide required information may result in the inability of Army Community Service to provide appropriate professional and/or development services to the individual.

Children:

ACS ASSISTS COMMANDERS IN MAINTAINING THE READINESS OF I NDIVIDUALS, FAMILIES, AND COMMUNITIES WITHIN AMERICA'S ARMY BY DEVELOPING, COORDINATI NG, AND DELIVERING SERVICES TO PROMOTE SELF-RELIANCE, RESILIENCY, AND STABILITY DURING WAR AND PEACE.

FORT STEWART OFFICE
191 LINDQUIST ROAD, BLDG 86
Fort Stewart, GA 31314
(912) 767-2882/5058
FAX (912) 767-2957

ARMY COMMUNITY SERVICE ACS Real-Life Solutions for Successful Army Living

HUNTER ARMY AIRFIELD OFFICE
171 HALEY AVE, BLDG 186
Hunter Army Airfield, GA 31409
(912) 315-6816
FAX (912) 315-2601

LAST NAME	FIRST NAME	SEX	DOB	AGE

REASON FOR REFERRAL:

_____

_____

_____

_____

_____

_____

_____

_____

I have been informed of this referral and I would like to be contacted for a home visit from the New Parent Support Program staff.

Parent Signature_____

ACS ASSISTS COMMANDERS IN MAINTAINING THE READINESS OF I NDIVIDUALS, FAMILIES, AND COMMUNITIES WITHIN AMERICA'S ARMY BY DEVELOPING, COORDINATI NG, AND DELIVERING SERVICES TO PROMOTE SELF-RELIANCE, RESILIENCY, AND STABILITY DURING WAR AND PEACE.

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