Gaston County Department of Health & Human Services

Maternity Clinic, 991 West Hudson Boulevard, Gastonia 28052
Summit Midwifery and High Risk Obstetrics, 890 Summit Crossing, Gastonia, 28054
Highland Health Center, 609 North Highland Street, Gastonia, 28052

Maternity Care

WELCOME to the Gaston County Health Department's Maternity Program. Our goal is to help you have a healthy pregnancy and a healthy baby!

Please read this sheet carefully and ask us to explain items you do not fully understand.

This document describes the services we offer at all of our maternity clinics – at Hudson Boulevard, Summit Midwifery and High Risk Obstetrics, and at the Highland Health Center. When you finish we will ask you to sign a consent form stating you have read and understand this document.

If you receive early and regular prenatal care you are more likely to have a healthy pregnancy and a healthy baby. We invite you to be our partner as we teach you about your pregnancy and how you can stay healthy.

We also want you to be aware of the risks when we draw your blood. You may faint or have redness, swelling, pain, bruising, bleeding, or, in rare cases, develop an infection where we insert the needle.

If you want to go to a private physician please let us know and we'll gladly give you a list of local physicians that provide obstetrical care. Please tell us if you decide to go to another medical practice. Whether you come to the health department or go to a private physician, it is very important that you receive regular prenatal care. Without prenatal care there may be medical problems that are not identified or treated that may affect you and your baby.

We only deliver babies at CaroMont Regional Medical Center. If you have medical problems we may admit you to the hospital for evaluations or care. We will have you sign a consent form for the delivery services we will provide.

General Information

During your ***first visit*** we will ask you to complete your Medical and Family History. We will also take blood, urine and vaginal specimens for the following tests. We will put the test results in your medical record and for special tests, which we have marked with (*), we will have you sign a special consent form.

Antibody screen
Blood group and type
Chlamydia screening
Complete Blood Count
Cystic Fibrosis Screening (optional) (*)
Gonorrhea screening
Hepatitis B
HgbA1C (blood sugar)
HIV / AIDS (*)
Random Drug Screen (*)
Rubella
Sickle cell screen (*)
Syphilis
Tuberculosis Screen (if needed)
Urinalysis
Varicella (chickenpox)

If we need to perform other lab tests we will talk about them with you.

Gaston County DHHS-Public Health
Maternity Care fit for you…

The DHHS-Public Health provides maternity care tailored to our patients' individual needs. Your particular needs will determine which type of care you need and which site you will attend.

Routine Maternity Care – DHHS-PH Hudson Blvd., Highland Health Center, or Summit Midwifery & High Risk Obstetrics, – this model is a traditional one-on-one healthcare with a Midwife, Nurse Practitioner or a physician.

Care Includes:

- Visits with the nurse followed by provider
- Individualized education
- Routine testing for mother's and baby's well being
- Focus on individual needs

High Risk Maternity Care – Summit Midwifery & High Risk Obstetrics, – this model is a traditional one-on-one healthcare with a Physician or Midwife. High Risk conditions include but are not limited to:

- Diabetes, Seizure Disorders, Mental Health Disorders, High Blood Pressure, Twins, Substance Use, History of Preterm Birth

Care Includes:

- Visits with the nurse followed by provider
- Individualized education
- Routine testing for mother's and baby's well being
- Focus on individual needs

We strongly encourage all maternity patients to attend our Childbirth Education classes lead by trained Childbirth instructors. Please call 704-853-5301 today to register.

We may also conduct a physical exam to check your weight, height, blood pressure, pulse, your breasts, and when we check your pelvis we may do a pap smear if indicated.

At the end of your first visit the visit schedule includes:

- Every 4 weeks until the 28th week of your pregnancy
- Every 2 weeks from the 28th to the 36th week of your pregnancy
- Every week between your 36th week and 40th week of pregnancy
- Twice a week after your 40th week of pregnancy. We deliver all babies before 42 weeks.

On your ***return visits,*** we may obtain, evaluate and update:

- Fetal heart tones and the size of your uterus, further testing if indicated
- Flu immunization will be offered to you if you are pregnant during flu season
- Medical history since your last visit
- MSAFP screening which assesses risk for Down Syndrome and Spina Bifida; we will have you sign a special consent form before taking this test
- HIV testing will be repeated during the third trimester
- Random drug screens will be performed as needed with your consent
- Screening for diabetes
- Weight, blood pressure and urine testing as indicated

As part of your ongoing care we may refer you for an ultrasound or to other specialists.

Phone numbers for questions or to leave messages for the nurse, Monday–Friday, 8:00 to 4:30

- **704-853-5009** for the Maternity Clinic on Hudson Boulevard
- **704-853-5464** for Summit Midwifery and High Risk Obstetrics
- **704-853-1550** for the Highland Health Center

Phone number to call and make or change appointments, Monday-Friday, 8:00 to 4:30

- **704-853-5009** Gaston County DHHS Call Center (Maternity Clinic on Hudson, Summit Midwifery and High Risk Obstetrics, and Highland Health Center)

Phone numbers to call if you have <u>urgent</u> problems

- For true emergencies, call 911

- When the ***<u>clinic is closed</u>*** (nights, weekends, holidays), please call the midwife at **704-470-2512**. <u>Do not go to the hospital</u> for non-emergent concerns without first calling and talking with the midwife. The midwife will instruct you on what to do. Calling first may prevent a visit to the Emergency Room. The midwife will not call in any medication refills after regular clinic hours. **When you call, please be ready to read information from your white card**. Please allow 1 hour for return call and answer your phone promptly. Return calls will be from the general hospital number 704-834-2000 (caller-ID).

- ***<u>Between 8:00 and 4:30</u>***, Monday thru Friday, call the clinic where you go for maternity care (phone numbers listed above)

  A message will be taken by the clerk and given to a Registered Nurse (RN). The RN will review the concern and review it with the clinician to determine what is best for you. A nurse or clinician will call you back, so stay close to the phone.

  When you call, please be ready to read information from your white card.

Danger signs to report immediately

- A significant decrease or NO fetal movement after 24 hours
- Burning, pain, or bleeding when passing urine
- Chest pain
- Chills or fever (greater than 100.4) that you've checked with a thermometer
- Continuous abdominal (uterine) pain
- Dizziness, blurred vision or seeing bright flashing lights
- Continuous leaking fluid or a gush of watery fluid from the vagina that will saturate more than one maxipad in an hour
- Regular cramping like pains in belly or back or other signs of labor before 37 weeks
- Severe headaches not relieved with Tylenol
- Swelling of hands, feet, or face not improved with rest, elevation or increasing water
- Vomiting or diarrhea more than 3 days
- Bright red vaginal bleeding that will saturate more than one maxipad in an hour

Exposure to Chickenpox:

- If you come in contact with someone who might have chickenpox, immediately call the Health Department at (704) 853-5009 ***Do not*** come into the clinic or go to the hospital. If the Health Department is closed, call the Midwife at **704-470-2512** and tell her the date and time you were exposed and your due date.

Patient Responsibilities: What you can do to take part in your prenatal care

- Keep your appointments and be on time. Failure to be on time may result in having to reschedule your appointment. If you cannot keep your appointment, call the call center or clinic before your appointment to discuss and reschedule.
- If you do not keep your appointments you may miss important tests and care
- Let us know if you have trouble with transportation
- Tell us immediately if you move and change your phone number so we can call you with lab results or if we need to change your appointment
- Participate in the classes and programs we offer: Childbirth classes, Breastfeeding classes, WIC, and Newborn and Post-Partum Home Visits
- Ask questions about your pregnancy or the care you are receiving
- Have your full name on your voicemail so that we can leave messages

Gaston County DHHS-Public Health
MATERNAL HEALTH HISTORY:
Nutrition Screen

Patient Label

To be completed by patient or appropriate staff. COMPLETE WITH BLACK INK ONLY

Please complete the following questions.
Put an "X" or check mark in the box for YES or NO, as it applies. List comments where requested or indicated. When completed, sign and date the form and return to the staff.

QUESTION	YES	NO	N/A	COMMENTS
Do you have any food allergies?				If "YES" – List allergies:
Do you skip meals 5 or more times a week?				
Are you lactose (milk) intolerant?				
Do you have trouble getting food?				
Do you want food or diet information?				
How do you plan to feed your baby?				☐ Breastfeed ☐ Formula ☐ Undecided
Did you have any problems breastfeeding your child(ren)?				
Have you had any breast surgery?				If "YES" – list procedure and date
Do you have any questions about breastfeeding?				
Do you follow a special diet?				If "YES" – list type or describe diet
Do you ever want to eat anything that is not food: ice, clay, dirt, laundry starch, washing powder, paper, gravel?				If "YES" – list
Do you now, or have you ever had an eating disorder: sever pica (eating non-food items), anorexia nervosa, bulimia, etc.?				If "YES" - list
Have you had any obesity reduction procedures such as gastric bypass?				If "YES" – list procedure and date

SECTION G: To be completed by staff.

Notes: _____
_____
_____

Interpreter Used: ☐ N/A ☐ No ☐ Yes Interpreter Name: _____

Referrals Made: ☐ None: ☐ Nutritionist ☐ WIC Other: _____

Signature of Reviewer: _____ Date: _____

The following diagnoses may require a nutritionist referral and care plan by nutritionist:

Previous low birth weight infant	Pre-pregnancy BMI <18.5	Autoimmune disorder (lupus, colitis, etc.)	Substance use
Intrauterine growth restriction	Inadequate weight gain	Hgb <10 gm or Hct < 30%	Multiple fetuses
Medications, Herbal supplement use	Maternal age 16 or younger	Pre-pregnancy overweight	Excessive weight gain
Metabolic Disorders (diabetes, PKU, thyroid dysfunction, etc.)		Chronic Infection (HIV/AIDS, hepatitis, etc.)	
Chronic Medical Disease (inflammatory bowel, hyperlipidemia, liver disease, renal disease, heart disease, hypertension, malabsorption syndromes)			

Gaston County DHHS-Public Health

Patient Label

MATERNAL HEALTH HISTORY:
Initial Psychosocial Screening

To be completed by patient or appropriate staff.
Please complete the following questions.
Put an "X" or check mark in the box for YES or NO, as it applies. List comments where requested or indicated. When completed, sign and date the form and return to the staff.

QUESTION	YES	NO	COMMENTS
Do you have any cultural or religious factors that would affect your healthcare choices?			List any cultural or religious preferences:
Are you experiencing any family or personal problems? *			
What is your highest completed level of education?			Last Grade Completed:
Are you employed?			
Do you have adequate and safe housing? *			List people you live with:
Do you have working appliances (stove, refrigerator, indoor plumbing, etc.?) *			List any problems or needs:
Do you have a source of transportation? *			List type of transportation:
Household Resources Adequate *			
Who are your support persons?			List support persons:
What are your plans for the baby? *			☐ Keep and Raise ☐ Adoption ☐ Other_____
Do you have any physical limitations or problems hearing, reading, speaking or understanding? *			List any physical limitations or problems:
Have you experienced any type of significant loss in the last year such as death, loss of job, housing, relationship breakup, major illness or a loved one in the military being deployed? +			If "YES" – add comments:
Over the past two weeks have you felt down, depressed or hopeless? +			If "YES" – add comments:
Over the past two weeks have you felt little interest or pleasure in doing things? +			If "YES" – add comments:
Over the past two weeks have you thought about hurting yourself or someone else? +			If "YES" – add comments:

Patient Signature: (if self-administered) _____ Date: _____

Interpreter Used: ☐ N/A ☐ Yes ☐ No Interpreter Name: _____

Reviewer's Signature: _____ Date: _____

*** Psychosocial/case management referral required** **** LCSW referral required** **+ Pyschosocial or LCSW referral required**

Name: _____

Date of Birth: _____

PERSONAL AND MEDICAL HISTORY

Note to Staff: Information to be entered into computer; form NOT to be scanned

__I have no history of any medical problems other than minor accidents or infections, and am taking no prescription medications.
__No one in my immediate family has any medical problems other than minor accidents or infections
__ I am adopted or estranged from my biological family and therefore do not know their medical histories

Please check if you or your immediate family members have had any of the following illnesses:
Siblings—means your biological brothers and sisters only

	Myself	Mother	Father	Sibling
__ Accidents __ motor vehicle __ fracture with cast or external set __ fracture with surgical set				
__ Anemia __ currently taking medication List_____ __ not currently taking medication __ never requiring medication __ have had blood transfusion for anemia date:_____				
__ Asthma __ currently taking medication List_____ __ not currently taking medication __ never requiring medication				
__Autoimmune diseases __Lupus __ Rheumatoid arthritis __ Other				
__Birth defects/Genetic disorders __Down Syndrome __ Cystic Fibrosis __Mental retardation __ Fragile X syndrome __Tay-sachs disease __Muscular dystrophy __Huntington's chorea __Neural tube defect (open spine, anencephaly, myelomeningiocele)				

	Myself	Mother	Father	Sibling
__Blood clots __ DVT __ pulmonary embolus				
__ Blood transfusion				
__ Breast problems __ Fibrocystic changes __Mastitis or abscess __ Fibroadenoma __Cyst or discharge __ Lump or mass __Cancer				
__ Cancer __Breast __Lung __Ovarian __Leukemia __Colon __Other-please list_____ __Cervical				
__ D (Rh) sensitized __Negative Blood Type				
__ Dental problems __Gum disease __Decay or cavities __Dentures or partial plates				
__ Diabetes __ Insulin use now ___Age started for self only __Gestational only __Tablets by mouth only __Diet controlled Provider prescribing medication_____				
__ Eating disorders __Anorexia __Binge eating __Bulimia __Pica ____				
__ Gastrointestinal disorders __Irritable bowel syndrome __GERD __Chronic constipation __Diverticulitis __Crohn's disease Self only: __Gastric Bypass Surgery __Year of Surgery _____ __Total weight loss to date _____				

	Myself	Mother	Father	Sibling
__ Headaches __Tension __Migraine **__Other** **Any prescription medicine for patient only_____** **Provider prescribing medication to patient_____**				
__ Heart disease **For self: ___Mitral valve prolapsed** **Do you take antibiotics __Yes __N0** ___ History of rheumatic fever ___ Born with heart defect Name of defect_____ No surgery required Year and hospital of surgical correction_____ When was your last exam with the cardiologist? _____ Family history __Heart attack __Stroke __Aneurysm __Surgery				
__ High blood pressure __ During pregnancy or labor only __ Not on medication __ Currently on medication(list)_____ Provider prescribing medication for self only_____				
History of Cytomegalovirus: ____ No ____ Yes				
History of Toxoplasmosis: ____ No ____ Yes				
__ Hyperlipidemia __ on medication __ not on medication				
__ Immune suppression/ HIV/ AIDS __Transplant recipient __AIDS __HIV positive __ Neutropenia __ On immunosuppression medication List: _____				

	Myself	Mother	Father	Sibling
__ Kidney or bladder problems __ Frequent UTI's __ History of kidney infections requiring medical care __ Kidney stones __ Stents ___Interstitial cystitis __Surgery ___Dialysis				
__ Liver or gallbladder problems __Gallbladder surgery __Gallstones __ Hepatitis: __ A __ B __ C __ cirrhosis __ Other liver disease (list) _____				
__ Menstrual problems __Irregular periods __ Heavy periods __ PCOS				
__ Mental health/psychiatric problems __Depression __Anxiety __Bipolar __Panic attacks __ADD or ADHD __Learning disabilities/delay __Autism or autism spectrum __Schizophrenia Patient only ___Suicide attempt ___year ___ hospitalization (give dates) _____ Do you have a legal guardian? __No ___Yes Legal guardian's name_____				
__ Musculoskeletal problems __MS (multiple sclerosis) __Dwarfism __MD(muscular dystrophy) __Scoliosis __Osteogenesis imperfecta				
__ Neurologic disorders __Epilepsy **Patient only __Eclampsia** __Epilepsy ___Age at diagnosis Date of last seizure_____ __Never on medication __On medication now List Name: _____ __On medication in the past List name_____ __Name/location of neurologist				

	Myself	Mother	Father	Sibling
__ Post-partum depression __ Treated with medication __ Treated with counseling __ Not treated/ resolved				
__ Pulmonary/ lung problem __Chronic bronchitis __Tuberculosis (TB) __COPD __Pneumonia If TB: have you completed INH Treatment? ___ Yes ___ No				
__ Sensory disorders __ hearing impaired __ require sign language interpreter __ blindness __ other (list) _____				
__ Skin diseases/Problems __Eczema __Psoriasis __Other—please list_____				
__ Sickle cell or blood abnormality __ Sickle cell trait ___Sickle cell disease __Thrombophilia ___Porphyria __Thallesemia ___Hemophilia __ Factor V Leiden __ Other hemoglobinopathy _____ _____				
__Thyroid problems __ hypothyroid __ hyperthyroid Please list any current medications_____				
__ Uterine abnormalities __ Bicornuate shape __ Septated uterus __ DES exposure __Fibroids documented by a clinician				
__ Varicose veins __ Below the knee __Thigh __Vulva				
__ Other pertinent medical history not listed above _____ _____				

SURGERY HISTORY: List all surgeries (including oral surgery) that you have had below:

Surgery	Date / Year

MEDICATIONS: List current medications (prescription and over-the counter including vitamins and supplements)

Medication	Dose

ALLERGIES: List all medication, food and other allergies

_____

_____

PHARMACY: List current pharmacy and location / phone number if known

Name: _____

Location: _____ Phone: _____

1. Last Name			First Name						MI	
2. Patient Number										
3. Date of Birth (MM/DD/YYYY)										
		Month		Day		Year				
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White										
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported										
6. Gender ☐ Female ☐ Male										
7. County of Residence										

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Women's Health Branch

Bilingual Lead and Pregnancy Risk Questionnaire

Answer each question by checking the small "YES," "NO," or "UNSURE" box.

Marque su respuesta a cada pregunta en la casilla indicada (Sí, No, o No sabe).

If there is at least one "yes or unsure" box checked off, the patient should have a blood lead test. The patient's care should be managed according to CDC guidelines based on test results.

	YES	NO	UNSURE
1. Have you ever had a high blood lead level? **¿Ha tenido usted alguna vez niveles de plomo altos en la sangre?**	☐ **Sí** ☐	☐ **No** ☐	☐ **No sabe** ☐
2. Have you spent any time outside of the United States in the past 12 months? If yes: Where? **¿Ha estado usted fuera de los Estados Unidos en los pasados 12 meses? Sí es Sí ¿Dónde?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐
3. Do you use pottery, remedies, spices, foods, candies or make-up that are not sold in a regular drug store or are homemade, but are sent to you from another country? **¿Usa usted cerámica, remedios caseros, especies, comida, dulces o maquillaje que son hechos en casa, o que no son vendidos en una farmacia regular, o son enviados de otro país?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐
4. Sometimes pregnant women have the urge to eat nonfood items such as clay, soil, plaster, paint chips, or crushed pottery. Do you ever eat any of these things—even accidentally? **Algunas veces las mujeres embarazadas tienen el impulso de comer arcilla (barro), tierra, yeso, pedazos de pintura o de cerámica. ¿Ha comido usted alguna vez uno de estos, aunque sea por accidente?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐
5. a) Was your home built before 1978? b) This past year, have there been any renovations in your home that involved sanding or scraping? **a) ¿Fue su casa construida antes de 1978?** **b) ¿Ha habido una remodelación en su casa donde se raspó o lijó algo?**	YES a) ☐ b) ☐ **Sí** **a)** ☐ **b)** ☐	NO a) ☐ b) ☐ **No** **a)** ☐ **b)** ☐	UNSURE a) ☐ b) ☐ **No sabe** **a)** ☐ **b)** ☐
6. Do you or others in your household have a job or a hobby that involves possible lead exposure, such as home renovation or working with stained glass, ceramics, jewelry, auto repair, battery manufacturing or firearms (projectiles, bullets or firing ranges)? **¿Usted o miembros de su familia tienen un trabajo o pasatiempo que implique la posible exposición a plomo, como son la renovación de casas o trabajos con vidrios de color, cerámica, joyería, reparación de vehículos o fabricación de baterías/pilas o armas de fuego (proyectiles, balas o campos de tiro)?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐

7. Based on the results of a laboratory test, have you been told there's lead in your home's water? **¿Con base en los resultados de una prueba de laboratorio, le han dicho que hay plomo en el agua de su casa?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐
8. Have any of your children had an elevated blood lead level (>5 µg/dL)? **¿Alguno de sus hijos ha tenido un nivel alto de plomo en la sangre (>5 ug/dL)?**	YES ☐ **Sí** ☐	NO ☐ **No** ☐	UNSURE ☐ **No sabe** ☐

Fecha

Bilingual Lead and Pregnancy Risk Questionnaire Instructions

Purpose: To assess and document past and present risk factors for lead exposure that may impact pregnancy.

Instructions: This form can be self-administered by the patient or verbally-administered by staff. Instruct the patient or staff to check off the responses of either "yes," "no," or "unsure" for each question. Regardless of who completes the form, it must be reviewed by staff to determine if clarifications are needed. If there is at least one "yes" box checked off, the patient should have a blood lead test and upon results, subsequently managed according to CDC Guidelines.

The best time to conduct this questionnaire is during the initial new obstetric intake. If a blood draw is needed, it should be conducted during the time of initial obstetric labs. However, this questionnaire can be administered any time during the pregnancy.

The CDC Guidelines can be accessed at www.cdc.gov/nceh/lead.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History, and the form should become part of the patient's medical record.

Location: Go to the following link to access this form and print as needed: http://whb.ncpublichealth.com/provPart/forms.htm.

Instrucciones para el cuestionario de riesgo de plomo durante el embarazo

Objetivo: Evaluar y documentar factores de riesgo pasados y presentes de la exposición al plomo que pueda afectar el embarazo.

Instrucciones: Este formulario puede ser auto-administrados por el paciente o verbalmente administrado por el personal. Instruir al paciente o al personal de marcar las respuestas de "sí", "no" o "no sabe" por cada pregunta. Independientemente de que complete el formulario, éste debe ser revisado por el personal para determinar si se necesitan aclaraciones. Si hay al menos un "sí" o un cuadro marcado con " no sabe", el paciente debe someterse a una prueba de plomo en la sangre y los resultados serán administrados posteriormente de acuerdo con las directrices de los CDC.

El mejor momento para realizar este cuestionario es durante la cita obstétrica inicial. Si se necesita una extracción de sangre, debe llevarse a cabo al mismo tiempo que se hacen los exámenes de laboratorio obstétricos iniciales. Sin embargo, este cuestionario se puede administrar en cualquier momento durante el embarazo.

Se pueden consultar las Directrices de los CDC en: www.cdc.gov/nceh/lead.

Disposición: Este formulario debe ser conservado en conformidad con el calendario de eliminación de documentos del historial clínico como se indica por la División de Archivos e Historia, y la forma debe ser parte del historial médico del paciente.

Localización: Vaya al siguiente enlace para acceder a este formulario e imprimir según sea necesario: http://whb.ncpublichealth.com/provPart/forms.htm.