	1			
Data Field			Applicable Forms	
(Bold and Italicized			1992, 1994, 1997,	
indicates field included	Field	Field	2001, 2004, 2008	
in public-use data set)	Type	Length	(see attachments)	Description of Data Values
ScreenId	char	13	1994-2008	Unique Identifier for Each Record e.g. P200001000001
				1992 - Not Applicable - Data Not Populated
ScreeningDate	datetime		1992-2008	1994-2008 - Date Prenatal Screen Provided
MotherMaidenName	varchar	15	1992	Not Applicable - Data Not Populated
				1992 - Not Applicable - Data Not Populated
MotherLastName	varchar	30	1992-2008	1994-2008 - Mother's Last Name
				1992 - Not Applicable - Data Not Populated
MotherFirstName	varchar	30	1992-2008	1994-2008 - Mother's First Name
MotherMiddleInt	char	1	2001-2008	Mother's Middle Initial
				1992 - Not Applicable - Data Not Populated
CountyOfRes	integer		1992-2008	1994-2008 - County of Residence 1-67 (see attachment)
				1992 - Not Applicable - Data Not Populated
StreetAddress	varchar	60	1992-2008	1994-2008 - Residential Street Address
				1992 - Not Applicable - Data Not Populated
CityName	varchar	50	1992-2008	1994-2008 - City of Residence
				1992 - Not Applicable - Data Not Populated
StateOfRes	integer		1992-2008	1994-2008 - State of Residence
				1992 - Not Applicable - Data Not Populated
ZipCode5	char	5	1992-2008	1994-2008 - Zip Code of Residence
MailStreetAddress	varchar	60	1994-2004	Mailing Street Address
MailCityName	varchar	50	1994-2004	Mailing City
MailState	char	2	1994-2004	Mailing State
MailZip5	char	5	1994-2004	Mailing Zip Code
				1992 - Not Applicable - Data Not Populated
HomePhone	char	10	1992-2004	1994-2004 - Home Phone Number
WorkPhone	char	10	1997-2004	Work Phone Number
				1992 - Not Applicable - Data Not Populated
MothersDOBMonth	char	2	1992-2008	1994-2008 - Mother's Month of Birth
				1992 - Not Applicable - Data Not Populated
MothersDOBDay	char	2	1992-2008	1994-2008 - Mother's Day of Birth
				1992 - Not Applicable - Data Not Populated
MothersDOBYear	char	4	1992-2008	1994-2008 - Mother's Year of Birth
				1992 - Not Applicable - Data Not Populated
MotherAge	integer		1992-2008	1994-2008 - Mother's Age
				1992 - Not Applicable - Data Not Populated
MomSSN	char	9	1992-2008	1994-2008 - Mother's Social Security Number (9-digit SSN, 9-digit pseudo, NULL, or Blank)
				1992 - Not Applicable - Data Not Populated
MomRace	char	1	1992-2004	1994-2004 - Mother's Race (W, B, O, NULL, or Blank)

				Opuateu 1717/00
				1992 - Not Applicable - Data Not Populated
				1994-2004 - Mother's Marital Status (Y, N, NULL or Blank)
MomMarried	char	1	1992-2008	2008 - Question 2. Mother's Marital Status (Y, N, NULL or Blank)
				1992 - Not Applicable - Data Not Populated
				1994-2004 - Mother Graduated from High School (Y, N, NULL or Blank)
HighSchool	char	1	1992-2008	2008 - Question 1. Mother Graduated from High School (Y, N, NULL or Blank)
LessThen55	char	1	1994-2008	Mother was Less than 5.5 lbs when she was born (Y, N, U or Blank)
WeightBefore	integer		1994-2008	1994-2004 - Mother's Weight Before Pregnancy in Ibs
HeightFeet	integer		1994-2008	Mother's Height - Feet Portion of Measurement
HeightInches	integer		1994-2008	Mother's Height - Inches Portion of Measurement
				1994-2004 - Mother's First Pregnancy (Y, N, NULL, or Blank)
FirstPreg	char	1	1994-2008	2008 - Question 15. Mother's First Pregnancy (Y, N, NULL, or Blank)
				1994-2004 - Month that Last Pregnancy Ended (1 to 12 or Blank)
DOLPMonth	char	2	1994-2008	2008 - Question 15. Month that Last Pregnancy Ended (1 to 12 or Blank)
				1994-2004 - Year that Last Pregnancy Ended (4-digit year or Blank)
DOLPYear	char	4	1994-2008	2008 - Question 15. Year that Last Pregnancy Ended (4-digit year or Blank)
		_		1994-2004 Coverage by Health Insurance/HMO (Y, No or Blank)
CoverageByHMO	char	1	1994-2008	2008 Prenatal Care Coverage by Private Insurance (Y, No or Blank)
HMOName	varchar	50	2001-2008	Name of Private Insurance or Health Insurance/HMO
CoverageByMed	char	1	1994-2008	Prenatal Care Coverage by Medicaid (Y, N, or Blank)
CoverageByOth	char	1	1994-2008	Prenatal Care Coverage by Other Insurance (Y, N, or Blank)
OtherInsName	varchar	50	2001-2008	Name of Other Insurance
NoCoverage	char	1	1994-2008	No Prenatal Care Coverage (Y, N, or Blank)
				Question 1. Do you have any problems that prevent you from keeping your health care or social services appointments?
Question1	char	1	1994-2004	(Y, N, NULL or Blank)
Question2	char	1	1994-2004	Question 2. Have you moved more than 3 times in last 12 months? (Y, N, NULL or Blank)
Question3	char	1	1994-2004	Question 3. Do you feel unsafe where you live? (Y, N, NULL or Blank)
Question4	char	1	1994-2004	Question 4. Do you or any member of your household go to bed hungry? (Y, N, NULL or Blank)
Question5	char	1	1994-2004	Question 5. In the last 2 months, have your used any form of tobacco? (Y, N, NULL or Blank)
				Question 6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)? (Y, N, NULL or
Question6	char	1	1994-2004	Blank)
1	_	_	4004 0000	1994-2004 - Question 7. In the last year, has anyone hit or tried to hurt you? (Y, N, NULL, or Blank)
Abused	char	1	1994-2008	2008 - Question 9. In the last year, has someone you know tried to hurt you or threaten you? (Y, N, or Blank)
Question8	char	1	1994-2004	Question 8. How do you rate your current stress level? (a) low, (b) medium, (c) high (A, B, C, Blank or NULL)
		,	4004.0004	Question 9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no
Question9	char	1	1994-2004	change? (A, B, C, D, Blank or NULL)
Question10	char	1	2001-2004	Question 10. Have you considered adoption for this pregnancy? (Y, N, NULL, or Blank)
				2001-2004 - Question 11. Do you now, or have you ever had, problems with depression? (Y, N, NULL, or Blank)
Question11	char	1	2001-2008	2008 - Question 6. In the lastmonth, have you felt down, depressed or hopeless? (Y, N, Blank)
				2001-2004 - Question 12. Do you have a history of receiving mental health counseling? (Y, N, NULL, or Blank)
MentalHealth	char	1	2001-2008	2008 - Question 8. Have you ever received mental health services or counseling? (Y, N, or Blank)
Question13	char	1	2001-2004	Question 13. Is your partner unemployed? (Y, N, X=Not Applicable, Blank or NULL)
				Question 14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5 1/2 pounds, a baby born
	_		000::	more than 3 weeks early, or a baby that stayed in the hospital after the patient went home? (Y, N, X=Not Applicable,
Question14	char	1	2001-2004	Blank or NULL)

MedicalCare	char	1	2001-2008	2001-2004 - Question 15. Does patient have any illness that requires continuing medical care? (Y, N, NULL or Blank) 2008 - Question 21. Does patient have an illness that requires ongoing medical care? (Y, N, or Blank)
				1992 - Not Applicable - Data Not Populated
ScreenConsent	char	1	1992-2008	1994-2008 - Screening Consent (1994-2004 - Y, N, or Blank) (2008 - Y or N)
ProgramConsent	char	1	1994-2004	Program Consent (1994-2001 - Y, N, NULL, Blank, or M)(2004- Y, N, NULL or Blank)
BestContactTime	varchar	50	2001-2008	Best Time to Contact Patient for Care Coordination
InfoRelease	char	1	2001-2004	Information Release Consent (Y, N, NULL or Blank)
ExceptABUSE	char	1	2001-2004	Information Related to Abuse Cannot be Released (X, NULL, or Blank)
ExceptALCDRUG	char	1	2001-2004	Information Related to Alcohol/Drug Use Cannot be Released (X, NULL, or Blank)
ExceptCCS	char	1	2001-2004	Information Cannot be Released for Care Coordination Outside of the Department of Health (X, NULL, or Blank)
ExceptELIG	char	1	2001-2004	Information Cannot be Used to Determine Program Eligibility (X, NULL, or Blank)
ExceptEVAL	char	1	2001-2004	Information Cannot be Used for Program Evaluation (X, NULL, or Blank)
ExceptHSCC	char	1	2001-2004	Information Cannot be Released to Healthy Start Care Coordination Providers (X, NULL, or Blank)
ExceptHCPrv	char	1	2001-2004	Information Cannot be Released to Health Care Provider Outside of the Department of Health (X, NULL, or Blank)
ExceptHFF	char	1	2001-2004	Information Cannot be Released to Healthy Families Florida (X, NULL, or Blank)
ExceptAIDS	char	1	2001-2004	Information Related to HIV/AIDS Cannot be Released (X, NULL, or Blank)
ExceptHSCOL	char	1	2001-2004	Information Cannot be Released to Healthy Start Coalitions (X, NULL, or Blank)
ExceptMEDICAL	char	1	2001-2004	Medical Information Cannot be Released (X, NULL, or Blank)
ExceptMental	char	1	2004	Mental Health Information Cannot be Released (X, NULL, or Blank)
ExceptPAY	char	1	2001-2004	Information Cannot be Released for Payment of Services (X, NULL, or Blank)
ExceptSTD	char	1	2001-2004	Information Related to Sexually Transmitted Diseases Cannot be Released (X, NULL, or Blank)
ExceptTB	char	1	2001-2004	Information Related to Tuberculosis Cannot be Released (X, NULL, or Blank)
ExceptWIC	char	1	2004	Information Cannot be Released to WIC (X, NULL, or Blank)
ExceptPSYCH	char	1	2001	Psychiatric Information Cannot be Released (X, NULL, or Blank)
ExceptPSYCHO	char	1	2001	Psychological Information Cannot be Released (X, NULL, or Blank)
Ехсеріготопо	Cliai	'	2001	
PatientSign	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Patient Signed Consent Statement(s) (1994-2004- Y, N, R=Refused, NULL, Blank)(2008 - Y or N)
ScreenConsentSign	char	1	1992-1997	Not Applicable - Data Not Populated
ProgramConsentDate	varchar	8	1992-1997	Not Applicable - Data Not Populated
ScreenConsentDate	varchar	8	1992-1997	Not Applicable - Data Not Populated
				2001-2004 - Month of Patient's Signature Related to Consent Statements
PatientDateMonth	char	2	2001-2008	2008 - Month of Date Patient Signed the Form
				2001-2004 - Day of Patient's Signature Related to Consent Statements
PatientDateDay	char	2	2001-2008	2008 - Day of Date Patient Signed the Form
				2001-2004 - Year of Patient's Signature Related to Consent Statements
PatientDateYear	char	4	2001-2008	2008 - Year of Date Patient Signed the Form
			400 1	1994-2004 - Question 15. Specific Illness
Illness	varchar	50	1994-2008	2008 - Question 21. Specific Illness
			4005 5555	1992 - Not Applicable - Data Not Populated
Provider's Name	varchar	50	1992-2008	1994-2008 - Provider's Name
ProviderID	char	6	1994-2008	Provider's 6-character ID Number

				1992 - Not Applicable - Data Not Populated
				1994-2004 - Provider's Practice Address was collected on Prenatal Screening Form
ProviderAdd	varchar	60	1992-2008	2008 - Provider's Practice Address is collected from Prenatal Screening Providers Database
				1992 - Not Applicable - Data Not Populated
				1994-2008 - Provider's City of Practice was collected on Prenatal Screening Form
ProviderCity	varchar	50	1992-2008	2008 - Provider's City of Practice is collected from Prenatal Screening Providers Database
ProviderCounty	char	2	1994-2008	Provider's County of Practice 1-67 (see attachment)
		_		1992 - Not Applicable - Data Not Populated
ProviderState	char	2	1992, 2008	2008 - Provider's State of Practice is collected from Prenatal Screening Providers Database 1-54, 99 (see attachment)
				1992 - Not Applicable - Data Not Populated
		_	1000 0000	1994-2004 - Provider's Zip Code of Practice was collected on Prenatal Screening Form
ProviderZip5	char	5	1992-2008	2008 - Provider's Zip Code of Practice is collected from Prenatal Screening Providers Database
		40	1000 0000	1992 - Not Applicable - Data Not Populated
ProviderPhone	char	10	1992-2008	1994-2008 Provider's Phone Number e.g. 8502454444
ProviderClass	char	1	1994-2008	Type of Provider (C= CHD provider, D=DOH contract provider, P=Private Provider, Other values are invalid)
5 6: 1			1000 0000	1992 - Not Applicable - Data Not Populated
ProvSigned	char	1	1992-2008	1994-2008 - Provider Signed the Screening Form? (1994-2004 - Y, N, NULL or Blank)(2008 - Y or N)
D 0: IM (I		0	1000 0000	1992 - Not Applicable - Data Not Populated
ProvSignedMonth	char	2	1992-2008	1994-2008 - Month of Provider's Signature
Duay Ciana ad Day	ah a	2	1002 2000	1992 - Not Applicable - Data Not Populated
ProvSignedDay	char	2	1992-2008	1994 - 2008 - Day of Provider's Signature
D Oi IV	-1	4	1002 2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Year of Provider's Signature
ProvSignedYear	char	4	1992-2008	
DOLLMonth	obor	2	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Month Last Normal Menses (LMP) Began
DOLLINOITH	char	2	1992-2000	1992 - Not Applicable - Data Not Populated
DOLLDay	char	2	1992-2008	1994-2008 - Day Last Normal Menses (LMP) Began
DOLLDay	Cital		1332-2000	1992 - Not Applicable - Data Not Populated
DOLLYear	char	4	1992-2008	1994-2008 - Year Last Normal Menses (LMP) Began
DOEDMonth	char	2	1994-2008	Month of Estimated Date of Delivery
DOEDDay	char	2	1994-2008	Day of Estimated Date of Delivery
DOEDYear	char	4	1994-2008	Year of Estimated Date of Delivery
DOEDTeal	Cital	7	1334-2000	1992 - Not Applicable - Data Not Populated
				1992 - Not Applicable - Data Not Populated 1994-2004 - Trimester of Pregnancy (1, 2, 3, NULL or Blank)
Trimester	char	1	1992-2008	2008 - Question 20. Trimester of Pregnancy (1, 2, 3, NULL or Blank)
Fullterm	char	2	1994-2004	OB History: Previous Full-term Pregnancies
Preterm	char	2	1994-2004	OB History: Previous Preterm Pregnancies OB History: Previous Preterm Pregnancies
Abortion	char	2	1994-2004	OB History: Previous Abortions
Living	char	2	1994-2004	OB History: Previous Live Births
LBW	char	2	1994-2004	OB History: Previous Low Birthweight Births
LDW	Cital		1334-2004	1992 - Not Applicable - Data Not Populated
ScoreEntered	tinyint		1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Prenatal Screening Score Determined by Screening Provider
ScoreComputed	tinyint		1994-2008	Prenatal Screening Score Calculated Later by Computer
InvitedScore		1	1994-2004	Invited Based on Score?
mviteascore	char	1	1994-2004	Invited pased on score?

				<u> </u>
InvitedOther	char	1	1994-2004	Invited Based on Other Factors?
				1992 - Not Applicable - Data Not Populated
InvitedHS	char	1	1992-1997	1994-1997 - Invited to Healthy Start
OtherFactor	varchar	150	1997-2008	Other Factors supporting invitation into Healthy Start
NotRefferred	char	1	1994-2004	Not Referred by Healthy Start Care Coordination
ReceivedatCHDDate	datetime		2004-2008	System Information - Date Screening Form Received at CHD from Provider
InputDate	datetime		2004-2008	System Information - Date of Data Entry at CHD
Status	varchar	30	2004-2008	Screening Status Assigned by System based on screening form responses
StatusDate	datetime		2004-2008	System-generated date when screening status is assigned
UserLastUpdating	varchar	30	2004-2008	System Information - Name of Person Entering Updated information
LastUpdated	datetime		2004-2008	System-generated date when screening information is updated
UploadStatus	char	7	2004-2008	System-generated (New Record=P, Changed Record=C, Delete Record=D)
UploadDate	datetime		2004-2008	System-generated date when record is uploaded
CensusTract	char	10		Not Applicable - Data Not Collected
PregOutCome1	varchar	30	2004, 2008	Outcome of 1st child delivered as a result of this pregnancy
PregOutDate1	datetime		2004, 2008	System-generated date when outcome of 1st child delivered is entered into system
DelWtGrams1	int		2004, 2008	Birthweight in grams of 1st child delivered
DelWtLbs1	smallint		2004, 2008	Birthweight pounds of 1st child delivered
DelWtOz1	smallint		2004, 2008	Birthweight ounces of 1st child delivered
GestWks1	smallint		2004, 2008	Gestation in weeks of 1st child delivered
PregOutCome2	varchar	30	2004, 2008	Mulitiple Birth: Outcome of 2nd child delivered as a result of this pregnancy
PregOutDate2	datetime		2004, 2008	Multiple Birth: System-generated date when outcome of 2nd child delivered is entered into system
DelWtGrams2	int		2004, 2008	Multiple Birth: Birthweight in grams of 2nd child delivered
DelWtLbs2	smallint		2004, 2008	Multiple Birth: Birthweight pounds of 2nd child delivered
DelWtOz2	smallint		2004, 2008	Multiple Birth: Birthweight ounces of 2nd child delivered
GestWks2	smallint		2004, 2008	Multiple Birth: Gestation in weeks of 2nd child delivered
PregOutCome3	varchar	30	2004, 2008	Mulitiple Birth: Outcome of 3rd child delivered as a result of this pregnancy
PregOutDate3	datetime		2004, 2008	Multiple Birth: System-generated date when outcome of 3rd child delivered is entered into system
DelWtGrams3	int		2004, 2008	Multiple Birth: Birthweight in grams of 3rd child delivered
DelWtLbs3	smallint		2004, 2008	Multiple Birth: Birthweight pounds of 3rd child delivered
DelWtOz3	smallint		2004, 2008	Multiple Birth: Birthweight ounces of 3rd child delivered
GestWks3	smallint		2004, 2008	Multiple Birth: Gestation in weeks of 3rd child delivered
PregOutCome4	varchar	30	2004, 2008	Mulitiple Birth: Outcome of 4th child delivered as a result of this pregnancy
PregOutDate4	datetime		2004, 2008	Multiple Birth: System-generated date when outcome of 4th child delivered is entered into system
DelWtGrams4	int		2004, 2008	Multiple Birth: Birthweight in grams of 4th child delivered
DelWtLbs4	smallint		2004, 2008	Multiple Birth: Birthweight pounds of 4th child delivered
DelWtOz4	smallint		2004, 2008	Multiple Birth: Birthweight ounces of 4th child delivered
GestWks4	smallint		2004, 2008	Multiple Birth: Gestation in weeks of 4th child delivered
PregOutCome5	varchar	30	2004, 2008	Mulitiple Birth: Outcome of 5th child delivered as a result of this pregnancy
PregOutDate5	datetime		2004, 2008	Multiple Birth: System-generated date when outcome of 5th child delivered is entered into system
DelWtGrams5	int		2004, 2008	Multiple Birth: Birthweight in grams of 5th child delivered
DelWtLbs5	smallint		2004, 2008	Multiple Birth: Birthweight pounds of 5th child delivered
DelWtOz5	smallint		2004, 2008	Multiple Birth: Birthweight ounces of 5th child delivered
			,	i to the state of

GestWks5	smallint		2004, 2008	Multiple Birth: Gestation in weeks of 5th child delivered
CaseID	varchar	6	2004	Not Applicable - System Information
DateExported	datetime		2004	Not Applicable - System Information
PIN	varchar	15	2004	Not Applicable - System Information
ReleaseHFF	char	1	2004	Not Applicable - System Information
ReleaseCC	char	1	2004	Not Applicable - System Information
ReleaseHSC	char	1	2004	Not Applicable - System Information
ReleaseWIC	char	1	2004	Not Applicable - System Information
ReleaseHCPrv	char	1	2004	Not Applicable - System Information
ReleaseQuestion4	varchar	80	2004	Not Applicable - System Information
ReleaseQuestion5	varchar	110	2004	Not Applicable - System Information
RowID	float	8		Not Applicable - System Information
SSN_SCRNDT	varchar	16		Not Applicable - System Information
OldMomZip4	char	4	1992	Not Applicable - Data Not Populated
OldProviderZip4	char	4	1992	Not Applicable - Data Not Populated
OldEduc	char	1	1992	Not Applicable - Data Not Populated
OldQues1	char	1	1992	Not Applicable - Data Not Populated
OldQues2	char	1	1992	Not Applicable - Data Not Populated
OldQues3	char	1	1992	Not Applicable - Data Not Populated
OldQues4	char	1	1992	Not Applicable - Data Not Populated
OldQues5	char	1	1992	Not Applicable - Data Not Populated
OldQues7	char	1	1992	Not Applicable - Data Not Populated
OldQues8	char	1	1992	Not Applicable - Data Not Populated
OldReportCnty	char	2	1992	Not Applicable - Data Not Populated
OldRepFlag	char	1	1992	Not Applicable - Data Not Populated
OldVoidFlag	char	1	1992	Not Applicable - Data Not Populated
IllnessOID	varchar	10	2008	System Data Field that points to description in Illness table, Illness field contains results for analysis
HSProvKey	varchar	10	2008	HSProvKey
ScrStatusOID	varchar	10	2008	Screen Status OID
FormYear	varchar	4	2008	Form Year (2004, 2008, or NULL)
Phone1	varchar	10	2008	Phone # 1
Phone2	varchar	10	2008	Phone # 2
RaceWhite	char	1	2008	Question 11. Race White (W)
RaceBlack	char	1	2008	Question 11. Race Black (B)
RaceOther	char	1	2008	Question 11. Race Other (O)
RaceSpecified	varchar	50	2008	Question 11. Race Other Specified
Smoke	char	1	2008	Question 13. Did not smoke? (Y,"")
Cigs	smallint	2	2008	Question 13. Number of Cigarettes
Alcohol	char	1	2008	Question 12. Did not Drink (Y "")
Drinks	smallint	3	2008	Question 12. Number of drinks
PregTiming	varchar	2	2008	Question 14. Pregnancy Timing (Not Pregnant=NOT, Pregnant Now=NOW, Pregnant Later=LATER, No Answer=Blank)
AsteriskSign	char	1	2008	Asterisk (*) Statement Signed (Y, N)

DateAstSign	datetime	10	2008	Date * Statement Signed (MM/DD/YYYY)			
ChildLT5	char	1	2008	Question 3. Children at Home Younger than 5 (Y, N, "")			
ChildNeed	char	1	2008	Question 4. Children at Home Medical/Special Need (Y, N, "")			
GoodTime	char	1	2008	Question 5. Good Time to be Pregnant? (Y, N, "")			
FeltAlone	char	1	2008	Question 7. Last Month Felt Alone (Y, N, "")			
PayBills	char		2008	Question 10. Trouble Paying Bills (Y, N, "")			
PPOStillbirth	char	1	2008	Question 16. Previous Pregnancy Outcome – Stillbirth (Y, "")			
PPOPreterm	char	1	2008	Question 16. Previous Pregnancy Outcome – Premature Birth (Y, "")			
PPOLBW	char	1	2008	Question 16. Previous Pregnancy Outcome – Low Birth Weight (Y, "")			
PPONone	char	1	2008	Question 16. Previous Pregnancy Outcome – None of the Above (Y, "")			
ReleaseInfo	char	1	2008	Patient Initialed Authorizing Release of Specific Information (Y, N, "")			
ВМІ	float	5	2008	Question 18. Body Mass Index (BMI)			
PregInt	char	1	2008	Question 19. Pregnancy Interval < 18 mos. (Y, N, Not Applicable=X,"")			
Referred	char	1	2008	Referred to Healthy Start (Y, "")			
NotRef	char	1	2008	Not Referred to Healthy Start (Y, "")			
CareCoor	varchar	50	2008	HS Care Coordinator Name			

County Code Numbers

County Code	County Name	County Code	County Name
1	ALACHUA	35	LAKE
2	BAKER	36	LEE
3	BAY	37	LEON
4	BRADFORD	38	LEVY
5	BREVARD	39	LIBERTY
6	BROWARD	40	MADISON
7	CALHOUN	41	MANATEE
8	CHARLOTTE	42	MARION
9	CITRUS	43	MARTIN
10	CLAY	44	MONROE
11	COLLIER	45	NASSAU
12	COLUMBIA	46	OKALOOSA
13	DADE	47	OKEECHOBEE
14	DESOTO	48	ORANGE
15	DIXIE	49	OSCEOLA
16	DUVAL	50	PALM BEACH
17	ESCAMBIA	51	PASCO
18	FLAGLER	52	PINELLAS
19	FRANKLIN	53	POLK
20	GADSDEN	54	PUTNAM
21	GILCHRIST	55	ST. JOHNS
22	GLADES	56	ST. LUCIE
23	GULF	57	SANTA ROSA
24	HAMILTON	58	SARASOTA
25	HARDEE	59	SEMINOLE
26	HENDRY	60	SUMTER
27	HERNANDO	61	SUWANNEE
28	HIGHLANDS	62	TAYLOR
29	HILLSBOROUGH	63	UNION
30	HOLMES	64	VOLUSIA
31	INDIAN RIVER	65	WAKULLA
32	JACKSON	66	WALTON
33	JEFFERSON	67	WASHINGTON
34	LAFAYETTE		

State/Territory Codes

State/Territory Name	State/Territory Abbreviation	State/Territory Code
Alabama	AL	1
Alaska	AK	2
Arizona	AZ	3
Arkansas	AR	4
California	CA	5
Colorado	CO	6
Connecticut	CT	7
Delaware	DE	8
District of Columbia	DC	9
Florida	FL	10
Georgia	GA	11
Hawaii	HI	12
Idaho	ID	13
Illinois	IL	14
Indiana	IN	15
lowa	IA	16
Kansas	KS	17
Kentucky	KY	18
Louisiana	LA	19
Maine	ME	20
Maryland	MD	21
Masachusetts	MA	22
Michigan	MI	23
Minnesota	MN	24
Mississippi	MS	25
Missouri	MO	26
Montana	MT	27
Nebraska	NE	28
Nevada	NV	29
New Hampshire	NH	30
New Jersey	NJ	31
New Mexico	NM	32
New York	NY	33
North Carolina	NC	34
North Dakota	ND	35
Ohio	ОН	36
Oklahoma	OK	37
Oregon	OR	38
Pennsylvania	PA	39
Rhode Island	RI	40
South Carolina	SC	41
South Dakota	SD	42
Tennessee	TN	43
Texas	TX	44
Utah	UT	45
Vermont	VT	46
Virginia	VA	47
Washington	WA	48
West Virginia	WV	49
Wisconsin	WI	50
Wyoming	WY	51
Puerto Rico	PR	52 53
Virgin Islands	VI	53 54
Guam	GU	54
Other or Unknown		99



Florida's Healthy Start Prenatal Risk Screening Instrument

e.	Name: First Last	Maiden	To be
, E	Address: Street or P.O. Box	City State Zip Code	completed by Health
SECTION	Phone Number	Residence County	Professional A<18 (1)
	Date of Birth (mm/dd/yy) Age Social Security Number	Race Married	A>35 (1)
		White Black Other Yes No	RB (1)
2 2		Provider's Phone Number	MN (1)
SECTION	Provider's Address		
SECTION 3	following information requested on this form, I under for which I am eligible.	Florida's Healthy Start and do NOT want to complete the erstand that this will not keep me from receiving services	
	Signature of Parent/Guardian	Pal (nm) dd/yy)	
SECTION 4	Screening Date (mm/dd/yy) LMP (mm/dd/yy) Trimester of	Pregnancy Weight before Pregnancy Height Feet Inches	3T (1) W<115 (1)
SE	Highest level of school completed: less than	high school greater than high school	ol E<12, A>18 (1)
SECTION 5	healthy babies who weighe 2. Do you have any illness that 3. Do you smoke ten or more 4. Do you ever drink more that drink a day? 5. Do you have a safe place to 6. Have you moved more than 7. Do you have transportation or social service appointme 8. Have you been treated for a 9. Inyou could change the time (a) earlier, (b) later, (c) not a	treduces communing medical care? ignielles a day? ion beer, one glass of wine, or one mixed live and enough food? three times in the last 12 months? problems which prevent you from keeping your health care ints? sexually transmitted disease in the last six months? ng of this pregnancy, would you want it it all, or (d) no change?	1N (2) 1N/A (1) 2Y (4) 3Y (1) 4Y (2) 5N (1) 6Y (1) 7Y (1) 8Y (1) 9C (1)
SECTION 6	Screening Score: Healt	e and invited to participate in ny Start Care Coordination: Yes No ning score and status for Healthy Start Care Coordination	
_	Interviewer's Signature and Title	Date (mm/dd/yy)	
SECTION 7		ate in Florida's Healthy Start and give permission for my bunty public health unit for care coordination. I understand	
	Signature of Parent/Guardian	Date (mm/dd/yy)	

Black ink only Florida's Healthy Start Prenatal Risk Screening Instrument

	1	Your name: First			Last			Your	county:		Today's Da	ite (month,da	ty,year)
	Y	our street address (a	apartment nur	mber):			Your city	or town:		Your state:		Your zip co	de: T
	Your mailing address (if different from street address): Your city or town: Your state: Your zip cod										de: c b P		
ATHENT	Your home phone: Your work phone or other: Your birthdate (month,day,year): Your age: Your social security number: Your race: black												
PATI	Ai	re you married?	H	_	d from high school or	received a GI	ED?			did you weigh		s or less?	A
BY I		our weight before p	regnancy:	Your heig		your first pre	gnancy? If	yes no, give date	no (month,yea	don't	regnancy en	ded (include	R
	L	yes no Date: live birth, stillbirth, miscarriage, abortion). Is your prenatal care covered by (check all that apply):											
LET		Health Insurance/HMO Medicaid other Health Insurance (Military, Indian Health, etc.)											
COMPLETED	th M	I am interested in being screened for Florida's Healthy Start. I understand that this information will be held strictly confidential. (If, yes, complete the following screening questions.) Me interesa hacer un reviso para el programa Comienzo Saludable. Comprendo que esta información se mantiene confidencialmente. Al contestar que sí, favor de contestar las siquientes preguntas.											
ä													
O	2 A	Yes No	are of Patient/		na del cliente o guar					Date (Fech			
SECTION	1. 2.				problems which pre more than 3 times in			our bealth	care or soci	al services ap	pointments	s?	1 2
SE	3.	. 🔲 🔲	3. Г	Do you feel unsa	fe where you live? ember of your house								3
	4. 5.		5. I	n the last 2 mon	ths, have you used a	ny form of to	bacco?						4 5
	6. 7.				ths, have you used d has anyone hit you o			ng beer, wi	ne, mixed d	rinks)?			6
	8.	a b c	8. H	Iow do you rate	your current stress	evel? (a) low,	(b) mediu						× 2
	9.	abc	d 9. I	t you could chan	ige the timing of this	pregnancy, v	would you	want it (a) e	earlier, (b) l	ater, (c) not	at all, (d) n	o change	9
										, , ,	***	to change	
	P	PROVIDER	-		PAI	ENT STOP H						to change	
		Yes No	N/A 1	10. Did patient's	last pregnancy resul	EXT STOP I	IERE	irth; a baby	less than 5	⁄² pounds; a l			
~	P 10 11	Yes No		3 weeks earl	last pregnancy resulty; or a baby that stay	ENT STOP I	IERE iage; stillb	irth; a baby	less than 59	½ pounds; a l			10
IDER	10 11	Yes No	1	3 weeks earl 11. Does patient	last pregnancy resul	ENT STOP I	iage; stillb spital after tinuing me	irth; a baby the patient dical care?	less than 59	½ pounds; a l			
OVIDER	10 11 Na	Yes No 0	alth Care Prov	3 weeks earl 11. Does patient	last pregnancy resulty; or a baby that stay	t in a miscarry yed in the hor requires con Provider's	iage; stillb spital after tinuing me	irth; a baby the patient dical care? §	less than 59 went home Specify illne 's Phone Nu	½ pounds; a l	oaby born n		10
PRC	10 11 Na	O. No O. I I I I I I I I I I I I I I I I I I I	alth Care Prov	3 weeks earl 11. Does patient	last pregnancy resulty; or a baby that stay have any illness that	t in a miscarrived in the ho requires con Provider's	iage; stillb spital after tinuing me ID	irth; a baby the patient dical care? § Provider	less than 55 went home Specify illne 's Phone Nu	½ pounds; a b	ed		10
_	10 11 Na	O. No O. I I I I I I I I I I I I I I I I I I I	alth Care Prov	3 weeks earl 11. Does patient	last pregnancy resulty; or a baby that stay have any illness that	t in a miscarry yed in the hor requires con Provider's	iage; stillb spital after tinuing me ID	irth; a baby the patient dical care? §	less than 59 went home Specify illne 's Phone Nu ty Where Pri ar) Trimes	½ pounds; a b ? ess mber	ed		10
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N 3 SECTION 2: BY PRO	Pro Pro III	O. Yes No O	lress lress lress lress r	3 weeks earl 11. Does patient ider Contracted Provider the number of infeterm Invit Invit Thy Start screening cr/Interviewer's Si in Florida's Heal will be held strictl an el programa Co	last pregnancy resulty; or a baby that stay have any illness that that have any illness	t in a miscarri yed in the ho requires con Provider's LMP (mo,dies than the lathy Start Construction of the lathy Start Const	iage; stillb spital after tinuing me ID Zip Code ay,year) EI Living are Coordinate Coordinat	country information.	less than 53 went home Specify illne 's Phone Nu ty Where Pri ar) Trimes at first Low Birti St ation to be a	// pounds; a let a	ed Healthy dination	more than	11
3 SECTION 2: BY PRO	Pro Pro III	O. Yes No O	lress lress lress lress r	3 weeks earl 11. Does patient ider Contracted Provider the number of infeterm Invit Invit Thy Start screening cr/Interviewer's Si in Florida's Heal will be held strictl an el programa Co	last pregnancy resulty; or a baby that stay have any illness that	t in a miscarri yed in the ho requires con Provider's LMP (mo,dies than the lathy Start Construction of the lathy Start Const	iage; stillb spital after tinuing me ID Zip Code ay,year) EI Living are Coordinate Coordinat	country information.	less than 53 went home Specify illne 's Phone Nu ty Where Pri ar) Trimes at first Low Birti St ation to be a	// pounds; a let a	ed Healthy dination	n. Yes/	11

Black ink only Florida's Healthy Start Prenatal Risk Screening Instrument

		Your name First	Las	or .		Ιv		1 90 1 10		_				
\neg		Tota name Tirst	1.20	St		10	our County	1 odays D	ate (month, day, year)					
7														
OKMATION		Your street address (apa	rtment number):		Your city or town			Your state:	Your zip code:					
							2 3 3 3 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5							
≤		Your mailing address (if	different from street address	s):	Your city or town			Your state:	Your zip code:	To be				
3	H				Tour state:				Tour zip code.	by He				
5	PATIENT									Profes				
Ĭ	H	Your home phone:	Tour race											
INF	H		white • other											
	P	Are you married?												
Ξ1	BY	yes 🗆 no 🗅		yes 🗖 no 🗖					don't know	MN	(2) (1)			
		Your weight before pres												
2	COMPLETED	The state of the s												
21	E	Is your prenatal care covered by (check all that apply): Health Insurance/HMO Medicaid Other Health Insurance (Military, Indian Health, etc.) No Coverage												
訚										EN W<11	U(1)			
5	8	I am interested in being following screening que	screened for Florida's Health	hy Start. I understar	nd that this informs	tion will be he	eld strictly confi	dential (If yes, con	aplete the Yes/Sí					
	2	Me interesa hacer un rev	riso para el programa Comies	nzo Saludable. Com	nprendo que esta in	formacion se	mantiene confid	lencialmente. Al c	statistics si.					
	8	favor de contestar las sic	quientes preguntas.											
	Z	Signature (of Patient/Guardian (Fir	rma del cliente o g	guardian)			Date (Fed	ha)					
	0	Yes No								_				
	SECTION 1:	1. 🗆 🗅	1. Do you have any	r problems whi	ch prevent you	from keen	no years bed	h en en ene	ial services appointments?					
		2.	2. Have you moved	more than 3 ti	imes in the last	12 months	ing your man	care or soc	at services appointments:	1Y 2Y	(1) (1)			
	S	3. 🗆 🗖	3. Do you feel unsa	afe where you li	ve?					3Y	(1)			
		4. 🗆 🗆	4. Do you or any n	nember of your	household go	o bed hun	27, 2			4Y	(1)			
		5. 0 0	5. In the last 2 mor	nths, have you u	used any form o	of tobacco				5Y	(1)			
		6. 0 0	6. In the last 2 mor	nths, have you u	ised drugs or al	cohol (in d	wing beer, w	wine, mixed dr	inks)?	6Y	(1)			
		7. □ □ □ 8. a□ b□c□	7. In the last year, l	has anyone hit y	ou or tried to l	nut you?	P 7311							
		9. a□ b□c□ d□	9. If you could cha	noe the timing	of this presence	iow (b) m	edium, (c) hi	gh	ter, (c) not at all, (d) no change	e 9C	(1)			
-			y rai y ou could call				ou want it (a	t) carner, (b) is	ter, (c) not at an, (d) no change	~	(1)			
Т				PATIENT	SIONER	2 and 10								
		CONTRACTOR OF THE				IXL								
	PR	OVIDER			0	ICL								
1	PR	Yes No N/A	40 10/1 - 1 - 1 1		C			1 20	0.000					
1	PR	COMPANIES SPECIAL DES	10. Did patient's la	st preg ant, re-	s It in a miscar	riage, stillbi	irth, a baby l	ess than 5½ p	ounds, a baby born more than	10Y	(1)			
	PR	Yes No N/A	3 weeks early, o	st pregrance res	solt in a miscar ayed in the hos	riage, stillbi	the patient w	ent home?	ounds, a baby born more than	101	(1) (1)			
		Yes No N/A 10.	3 weeks early, o	st pregrance res	salt in a miscar ayed in the hos hat requires con	riage, stillbi pital after t	the patient w	ent home? Specify illness		101	(1) (1)			
		Yes No N/A	3 weeks early, o	st pregrance res	salt in a miscar ayed in the hos hat requires con	riage, stillbi	the patient w	ent home?		101	(1) (1)			
		Yes No N/A 10.	3 weeks early, of 11. Does patient has h Care Provider	st pregnancy res or a baby that st ave any inness th	ayed in the hos	riage, stillbi pital after t atinuing m Provider's ID	the patient w	Provider's Phon	e Number	101	(1) (1)			
	OVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient has h Care Provider	st pregrance res	ayed in the hos	riage, stillbi pital after t	the patient w	Provider's Phon		101	(1) (1)			
	PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient has h Care Provider	st pregnancy res or a baby that st ave any inness th	solt in a miscar ayed in the hos hat requires con	riage, stillbi pital after t ntinuing m Provider's ID Zip Code	the patient w	Provider's Phon County Where I	e Number Practice is Located	101	(1) (1)			
	PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat h Care Provider	est pregnancy resor a basic that strawe any liness the	ayed in the hos	riage, stillbi pital after t ntinuing m Provider's ID Zip Code	the patient w	Provider's Phon County Where I	e Number Practice is Located pregnancy	101	(1) (1)			
	BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat the Care Provider ess	st pregnancy resor a baby that strave any liness the	alt in a miscar ayed in the hos hat requires con	riage, stillbi pital after t atinuing m Provider's ID Zip Code	the patient w	Provider's Phon County Where I	e Number Practice is Located pregnancy	101	(1)			
	2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat h Care Provider	st pregnancy resor a baby that strave any liness the Gity or Town	alt in a miscar ayed in the hos hat requires con LMP (mo,da)	riage, stillbi pital after t atinuing m Provider's ID Zip Code	the patient wedical care? S	Provider's Phon County Where I Trimester of at first prena	e Number Practice is Located pregnancy	iiiy	(1)			
	2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat he Care Provider less control of the Care Provider Latery Enterthe number of it Preterm	st pregrants respond to a basy that strong any inness the VCity or Town	LMP (mo,day	riage, stillbi pital after t atinuing m Provider's ID Zip Code	the patient weedical care? S D (mo,day,year)	Provider's Phon County Where I Trimester of at first prena	e Number Practice is Located pregnancy tal visit	iiiy	(1)			
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	SECTION 2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat he Care Provider ess OOH Observated Servider Care provider and the care Provider Invited to participate and based on score based on factors based on factors ent's Healthy Start screening	St pregnancy response to a baby that staye any indess the we any indess the weary indess the Caty or Town Private Provider Infants in each area. Abortion in Healthy Start Cats other than score. So score and status for	IMP (mo,day (Use zero for non Living re Coordination	riage, stillbi pital after t atinuing m Provider's ID Zip Code	D (mo,day,year)	Provider's Phon County Where I Trimester of at first prena By the County Where I Trimester of at first prena Sight	e Number Practice is Located pregnancy cal visit	iiiy	(1)			
	SECTION 2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat he Care Provider ess OOH Obseracted Servider Care Preterm Invited to participate Dased on score based on factors ient's Healthy Start screening wider/Interviewer's Signature	St pregnancy response to a baby that staye any indess the we any indess the weary indess the City or Town Private Provider Infants in each area. Abortion in Healthy Start Cases other than score. So score and status for the and Title	LMP (mo,da) (Use zero for non Living LYP Coordination Specify r Healthy Start Car	riage, stillbipital after the tinuing me Provider's ID Zip Code (year) ED	D (mo,day,year) Low Birth Wei	Provider's Phon County Where I Trimester of at first prena light Not referred fo Care Coordina Date	e Number Practice is Located pregnancy tal visit Thealthy Start tion	iiiy	(1)			
	3 SECTION 2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat he Care Provider ess OOH Observated Servider Care provider Interview number of in Preterm Invited to participate in Flore based on factors in the Start screening wider/Interviewer's Signature in the participate in Flore	St pregnancy response to a baby that strong any indess the control of the control	LMP (mo,day (Use zero for non- Living re Coordination Specify re Healthy Start Car	riage, stillbipital after that intinuing me Provider's ID Zip Code (year) ED a)	D (mo,day,year) Low Birth Wei	Provider's Phon County Where I Trimester of at first prena light Not referred fo Care Coordina Date	e Number Practice is Located pregnancy tal visit r Healthy Start tion	iiiy	(1)			
	3 SECTION 2: BY PROVIDER	Yes No N/A 10.	3 weeks early, of 11. Does patient hat he Care Provider ess OOH Observed Servider Care Provider Invited to participate and based on score based on factors based on factors ent's Healthy Start screening wider/Interviewer's Signature on to participate in Fl coordination. I under	St pregnancy response to a baby that strong any indess the control of the control	LMP (mo,day (Use zero for non- Living are Coordination Specify or Healthy Start Car Start. If yes, of information with	riage, stillbipital after that intinuing me Provider's ID Zip Code (year) ED c) ED c) The Coordination of the Provider's ID the Prov	D (mo,day,year) Low Birth Wei	Provider's Phon County Where I Trimester of at first prena I Not referred fo Care Coordina Date Lion for my inflential.	e Number Practice is Located pregnancy tal visit Thealthy Start tion Ormation Yes/Si	iiiy	(1)			
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DH 3134, 9/97 (Replaces previous editions which may be used) (Stock Number: 5744-100-3134-7)

Distribution of copies:

WHITE & YELLOW - To County Health Department in county where screening occurred PINK - Retained in patient's record

GREEN - Patient's copy

Black ink only Florida's Healthy Start Prenatal Risk Screening Instrument Today's Date (month, day, year): Census Tract (local use) Your street address (apartment complex name/number): Your city or town: Your state: Your zip code: Your mailing address (if different from street address): To be Your city or town: Your state Your zip code: completed by Health **Professional** Your home phone: Your work phone or other: Your birthdate (month, day, year): Your social security numb Your race: black A<18 white 🗖 A>39 (1) RB Are you married? Have you graduated from high school or received a GED? (2)When you were born, did you weigh 51/2 pounds or less? yes 🗖 no 🗖 yes 🗖 no 🗖 don't know 🗖 MN PHN Your weight before pregnancy: Your Height: Is this your first pregnancy? If no, give date your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). yes 🗖 no 🗖 Date: (month, year) Is your prenatal care covered by: Health Insurance/HMO Medicaid Other Health Insurance (Military, Indian Health, etc.) W<110 (1) No Coverage 🛘 If you would like to be screened for Healthy Start, please write your initials under yes. If not, write your initials under no. Please sign your name at the bottom of this section. ΒY Yes No (initials) **SECTION 1: COMPLETED** I am interested in being screened for Florida's Healthy Start. If yes, complete the following screening questions by checking the appropriate boxes. Yes No N/A (check marks) Do you have any problems which prevent you from keeping your health care or social services appointments? 1Y 00000 2. 4. 5. 6. 7. 8. 9. 2 Have you moved more than 3 times in the last 12 months? 2Y T (1) Do you feel unsafe where you live? 3Y Do you or any member of your household go to bed hungry? **4**Y In the last 2 months, have you used any form of tobacco? 5Y In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)? 6Y T (1) In the last year, has anyone hit you or tried to hurt you? а□Ъ□с□ 7Y T How do you rate your current stress level? (a) low, (b) medium, (c) high 8C T aDbOcO dO If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change 10. 9C T (1) Have you considered adoption for this pregnancy? 10Y T 11. Do you now, or have you ever had, problems with depression? 11Y T 12. 12. Do you have a history of receiving mental health counseling? 12Y T 13. Is your partner unemployed? 13Y T No (initials) If you would like to participate in the program if invited, please write your initials under yes. If not, initial no. If I am invited, I accept the invitation to participate in Florida's Healthy Start. The best time to contact me is: Please initial yes or no for consent to release information on this form and any information from the initial contact for the purposes below. Yes No (initials) The information on this form is confidential, and will not be released without my written consent. I hereby authorize the release of any information on this form and any information from the initial contact to Healthy Start care coordination providers, Healthy Start Coalitions, and where available, Healthy Families Florida for the following purposes: for care coordination services, to pay for claims for services, to evaluate service delivery, or to screen for program eligibility. This includes any medical, psychiatric, psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information that is included on this form or provided by me during the initial contact. Signature of patient or guardian Date (mm/dd/yy) No N/A 14. 14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5½ pounds, a baby born more than 3 weeks early, or a baby that stayed in 14Y the hospital after the patient went home? 15. 15Y (1) 15. Does patient have any illness that requires continuing medical care? Specify illness: ROVID Name and Title of Health Care Provider: Provider's ID: Provider's Phone Number: Provider's Mailing Address: City or Town: County Where Practice is Located: Zip Code: B LMP (mo,day,year) EDD (mo,day,year) Trimester of pregnancy at first prenatal visit: ☐ CHD Provider ☐ DOH Contracted Provider ☐ Private Provider =2T Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.) 2 or 3T T ผู Preterm Abortion Low Birth Weight (less than 51/2 pounds) Healthy Start ☐ Invited to participate in Healthy Start based on score. CHECK ☐ Invited to participate in Healthy Start based on factors other than score. Specify: ONE ☐ Not referred for Healthy Start. I have explained the Healthy Start program, and if screened, the screening score. S Provider's/Interviewer's Signature and Title Date (mm/dd/yy)



PRENATAL RISK SCREEN



This form must be completed in ink.

Pursuant to § 383.14(1)(a) and 383.011(1)(e), F.S., this form must be completed by the health care provider for every pregnant woman and submitted to the local county health department.

	Name: First	Last		M.I.	County:	Today's Dat	e (month/day/year):		Census Traci (local use)	
	Street address (apartment complex name/number):		City or town:		State: Zip code:					
	Mailing address (if differe	failing address (if different from street address):			City or town:		Zip code:	comp Heal	To be completed by Health	
	Home phone:	Work phone or oth				security number:	w	k 🗆 hite 🗅 other 🗅	Professional A<18 (1) A>39 (1) RB (2)	
븢	Are you married? yes 🖸 no 🖸		from high school or rec yes 🗆 no 🗅	×		yes 🗖 no	you weigh 5½ pounds O don't know O		MN T (1) PHN T	
PATIENT	Weight before pregnancy: lbs.	ft. in.	Is this your first pregna stillbirth, miscarriage, a	ancy? yes no abortion).	If no, give dat te: (month/year)_	e your last pregnan	cy ended (include live l	birth,		
ВУР	s your prenatal care covered by:							Coverage 🗖	EN T (1) W<110 (1)	
PLETED	Yes No (please initial) I am interested in being screened for risks that could affect my pregnancy, my health, or my baby. If yes, complete the following screening questions by checking the appropriate boxes.									
1: COMPLE	Yes No N/A 1.	2. Have you moved more than 3 times in the last 12 months? 3. Do you feel unsafe where you live? 4. Do you or any member of your household go to bed hungry? 5. In the last 2 months, have you used any form of tobacco?								
SECTION	7.	7. In the last ye 8. How do you 9. If you could 10. Have you co 11. Do you now 12. Do you have	rate your current streed change the timing of the sidered adoption for the property of receiving the	or tried to hurt ss level? (a) low this pregnancy, this pregnancy, l, problems with	t you? (b) medium, (c) (c) would you want (c) the depression?) high) no change	6Y T (1) 7Y T 8C T 9C T (1) 10Y T 11Y T 12Y T 13Y T	
	Yes No (please initial) If I am referred, Healthy Start may contact me. The best time to contact me is:									
	Healthy Start Coalitions of claims for services, c alcohol/drug abuse, ser remain in effect unless	on this form and any information provided during my evaluation for service by Healthy Start to Healthy Start care coordination provided Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, particularly for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization sharemain in effect unless withdrawn in writing.								
	Yes No N/A					Date (mo/day/				
ER		14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5½ pounds, a baby born more than 3 weeks early, or a baby that stayed in the hospital after the patient went home?								
ROVID	Name and Title of Health			Provider's II		Provider's Phone	: Number:			
4	Provider's Mailing Addres	ss:	City or Town:	Zip Code:		County Where I	ractice is Located:			
2: BY	CHD Provider DO Previous Obstetrical History			LMP (mo/day/) (Use zero for nor	,	ay/yr) Trimester	of pregnancy at 1st pr	renatal visit:	=2T (1) 2 or 3T T	
ECTION	Term Pr	Healthy Start creening CHECK ONE Referred to Healthy Start based on score. Referred to Healthy Start based on factors other than score. Specify:								
S	I have explained the									



Help your baby have a healthy start in life!



Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are <u>confidential</u>. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

		•							
Tod	day's Date:		YES NO						
1.	Have you graduated from high school or received a GED?			1	11. What race are you? Check one or more.□ White □₃ Black □ Other				
2.	Are you married now?			1	12. In the last month, how many alcoholic drinks did yo have per week?				
3.	Are there any children at home younger than 5 years old?		00		drinks₁ ☐ did not drink				
4.	Are there any children at home with medical or special needs?		-		13. In the last month, how many cigarettes did you smoke a day? <i>(a pack has 20 cigarettes)</i>				
5.	Is this a good time for you to be pregnant?		00		cigarettes				
6.	In the last month, have you felt down, depressed or hopeless?		■ 1 ■		14. Thinking back to just before you got pregnant, did you want to be?□ pregnant now□ pregnant later□₁ not pregnant				
7.	In the last month, have you felt alone when facing problems?				15. Is this your first pregnancy? □₂ Yes □ No I no, give date your last pregnancy ende				
8.	Have you ever received mer services or counseling?	ntal health			16. Please mark	Date: (mont	:h/year)		_
9.	In the last year, has someone you know tried to hurt you or threaten you?				☐3 Had a baby that was not born alive ☐3 Had a baby born 3 weeks or more before due date				
10.	D. Do you have trouble paying your bills?				□₃ Had a ba □ None of t	by that weighed the above	d less than	5 pounds	, 8 ounces
Nam	e: First Last	t	M.I.	Social Sec	urity Number:	Date of Birth (m	o/day/yr):	17. Age:	■ ₁ <18
Stree	et address (apartment complex nam	ne/number):	C	County:		City:	State:	l	Zip Code:
Prenatal Care covered by: Medicaid Private Insurance No Insurance Other				Best time	to contact me:	Phone #1			
Hea serv	thorize the exchange of my healthy Families Florida, WIC, Floridices, improving quality of services.	da Department of H	Health, and	d my heal	th care providers that the care providers the care	for the purposes fect until revoke	of providing	ng services	
	ent Signature: ase initial: Yes				health information tal health, TB, alc	n to be exchang			
	you do not want to participate in the granture:	screening process, p	olease comp	plete the pa		ction only and sigre:			
LMP (mo/day/yr): EDD (mo/day/yr):									1 < 19.8 $1 > 35.0$
Provider's Name: Provider's ID:					nancy Interval Less			_	I ₁ Yes
								_ ₁ 2nd	
Provider's Phone Number: Provider's County:			+	patient have an illne					
				Spec	fy illness:			□ No	2 Yes
	althy Start eening Score:	Check One: ☐ R ☐ N			v Start. If score < althy Start.	6, specify:			
	L								

Provider's/Interviewer's Signature and Title

Date (mo/day/yr)