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

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MomMarried	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2004 - Mother's Marital Status (Y, N, NULL or Blank) 2008 - Question 2. Mother's Marital Status (Y, N, NULL or Blank)
HighSchool	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2004 - Mother Graduated from High School (Y, N, NULL or Blank) 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 lbs
HeightFeet	integer		1994-2008	Mother's Height - Feet Portion of Measurement
HeightInches	integer		1994-2008	Mother's Height - Inches Portion of Measurement
FirstPreg	char	1	1994-2008	1994-2004 - Mother's First Pregnancy (Y, N, NULL, or Blank) 2008 - Question 15. Mother's First Pregnancy (Y, N, NULL, or Blank)
DOLPMonth	char	2	1994-2008	1994-2004 - Month that Last Pregnancy Ended (1 to 12 or Blank) 2008 - Question 15. Month that Last Pregnancy Ended (1 to 12 or Blank)
DOLPYear	char	4	1994-2008	1994-2004 - Year that Last Pregnancy Ended (4-digit year or Blank) 2008 - Question 15. Year that Last Pregnancy Ended (4-digit year or Blank)
CoverageByHMO	char	1	1994-2008	1994-2004 Coverage by Health Insurance/HMO (Y, No or Blank) 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)
Question1	char	1	1994-2004	Question 1. Do you have any problems that prevent you from keeping your health care or social services appointments? (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)
Question6	char	1	1994-2004	Question 6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)? (Y, N, NULL or Blank)
Abused	char	1	1994-2008	1994-2004 - Question 7. In the last year, has anyone hit or tried to hurt you? (Y, N, NULL , or Blank) 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)
Question9	char	1	1994-2004	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 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)
Question11	char	1	2001-2008	2001-2004 - Question 11. Do you now, or have you ever had, problems with depression? (Y, N, NULL, or Blank) 2008 - Question 6. In the lastmonth, have you felt down, depressed or hopeless? (Y, N, Blank)
MentalHealth	char	1	2001-2008	2001-2004 - Question 12. Do you have a history of receiving mental health counseling? (Y, N, NULL, or Blank) 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)
Question14	char	1	2001-2004	Question 14. Did patient's last pregnancy result in a miscarriage, stillbirth, a baby less than 5 1/2 pounds, a baby born more than 3 weeks early, or a baby that stayed in the hospital after the patient went home? (Y, N, X=Not Applicable, Blank or NULL)

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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)
ScreenConsent	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 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)
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
PatientDateMonth	char	2	2001-2008	2001-2004 - Month of Patient's Signature Related to Consent Statements 2008 - Month of Date Patient Signed the Form
PatientDateDay	char	2	2001-2008	2001-2004 - Day of Patient's Signature Related to Consent Statements 2008 - Day of Date Patient Signed the Form
PatientDateYear	char	4	2001-2008	2001-2004 - Year of Patient's Signature Related to Consent Statements 2008 - Year of Date Patient Signed the Form
Illness	varchar	50	1994-2008	1994-2004 - Question 15. Specific Illness 2008 - Question 21. Specific Illness
Provider's Name	varchar	50	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Provider's Name
ProviderID	char	6	1994-2008	Provider's 6-character ID Number

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ProviderAdd	varchar	60	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2004 - Provider's Practice Address was collected on Prenatal Screening Form 2008 - Provider's Practice Address is collected from Prenatal Screening Providers Database
ProviderCity	varchar	50	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Provider's City of Practice was collected on Prenatal Screening Form 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)
ProviderState	char	2	1992, 2008	1992 - Not Applicable - Data Not Populated 2008 - Provider's State of Practice is collected from Prenatal Screening Providers Database 1-54, 99 (see attachment)
ProviderZip5	char	5	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2004 - Provider's Zip Code of Practice was collected on Prenatal Screening Form 2008 - Provider's Zip Code of Practice is collected from Prenatal Screening Providers Database
ProviderPhone	char	10	1992-2008	1992 - Not Applicable - Data Not Populated 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)
ProvSigned	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Provider Signed the Screening Form? (1994-2004 - Y, N, NULL or Blank)(2008 - Y or N)
ProvSignedMonth	char	2	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Month of Provider's Signature
ProvSignedDay	char	2	1992-2008	1992 - Not Applicable - Data Not Populated 1994 - 2008 - Day of Provider's Signature
ProvSignedYear	char	4	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Year of Provider's Signature
DOLLMonth	char	2	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Month Last Normal Menses (LMP) Began
DOLLDay	char	2	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2008 - Day Last Normal Menses (LMP) Began
DOLLYear	char	4	1992-2008	1992 - Not Applicable - Data Not Populated 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
Trimester	char	1	1992-2008	1992 - Not Applicable - Data Not Populated 1994-2004 - Trimester of Pregnancy (1, 2, 3, NULL or Blank) 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
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
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	char	1	1994-2004	Invited Based on Score?

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InvitedOther	char	1	1994-2004	Invited Based on Other Factors?
InvitedHS	char	1	1992-1997	1992 - Not Applicable - Data Not Populated 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

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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)

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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, “”)
BMI	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
Iowa	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	OH	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
Virgin Islands	VI	53
Guam	GU	54
Other or Unknown		99

TYPE OR PRINT IN BLACK INK

Florida's Healthy Start Prenatal Risk Screening Instrument

SECTION 1

Name: First | Last | Maiden

Address: Street or P.O. Box | City | State | Zip Code

Phone Number | Residence County

Date of Birth (mm/dd/yy) | Age | Social Security Number | Race: White ☐ Black ☐ Other ☐ | Married: Yes ☐ No ☐

SECTION 2

Name of Health Care Provider | Provider's Phone Number

Provider's Address

SECTION 3

I am NOT interested at this time in participating in Florida's Healthy Start and do NOT want to complete the following information requested on this form. I understand that this will not keep me from receiving services for which I am eligible.

Signature of Parent/Guardian | Date (mm/dd/yy)

SECTION 4

Screening Date (mm/dd/yy) | LMP (mm/dd/yy) | Trimester of Pregnancy | Weight before Pregnancy | Height: Feet Inches

Highest level of school completed: ☐ less than high school ☐ high school ☐ greater than high school

SECTION 5

Yes	No	N/A		
☐	☐	☐	1. In your previous pregnancies, did you carry the babies for nine months and deliver healthy babies who weighed 5½ pounds or more?	1N (2) / 1N/A (1)
☐	☐		2. Do you have any illness that requires continuing medical care?	2Y (4)
☐	☐		3. Do you smoke ten or more cigarettes a day?	3Y (1)
☐	☐		4. Do you ever drink more than one beer, one glass of wine, or one mixed drink a day?	4Y (2)
☐	☐		5. Do you have a safe place to live and enough food?	5N (1)
☐	☐		6. Have you moved more than three times in the last 12 months?	6Y (1)
☐	☐		7. Do you have transportation problems which prevent you from keeping your health care or social service appointments?	7Y (1)
☐	☐		8. Have you been treated for a sexually transmitted disease in the last six months?	8Y (1)
			9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, or (d) no change?	9C (1)

a ☐ b ☐ c ☐ d ☐

SECTION 6

Healthy Start Screening Score: _____

Eligible and invited to participate in Healthy Start Care Coordination: ☐ Yes ☐ No

I have explained the patient's Healthy Start screening score and status for Healthy Start Care Coordination.

Interviewer's Signature and Title | Date (mm/dd/yy)

SECTION 7

By signing below, I accept the invitation to participate in Florida's Healthy Start and give permission for my risk screening information to be sent to my local county public health unit for care coordination. I understand that this information will be held strictly confidential.

Signature of Parent/Guardian | Date (mm/dd/yy)

To be completed by Health Professional

A<18	(1)
A>35	(1)
RB	(1)
MN	(1)
3T	(1)
W<115	(1)
E<12; A>18	(1)

HRS-H Form 3134, Mar 92
(Stock Number: 5744-000-3134-4)

Distribution of Copies: WHITE & YELLOW - To County Public Health Unit
PINK - Retained in Patient's Record

Black ink only

Florida's Healthy Start Prenatal Risk Screening Instrument

PATIENT

DEMOGRAPHIC INFORMATION — SECTION 1: COMPLETED BY PATIENT

Your name: First	Last	Your county:	Today's Date (month,day,year)
Your street address (apartment number):	Your city or town:	Your state:	Your zip code:
Your mailing address (if different from street address):	Your city or town:	Your state:	Your zip code:

Your home phone:	Your work phone or other:	Your birthdate (month,day,year):	Your age:	Your social security number:	Your race: black ☐ white ☐ other ☐

Are you married? yes ☐ no ☐

Have you graduated from high school or received a GED? yes ☐ no ☐

When you were born did you weigh 5 ½ pounds or less? yes ☐ no ☐ don't know ☐

Your weight before pregnancy: | Your height: | Is this your first pregnancy? If no, give date (month,year) your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). yes ☐ no ☐ Date:

Is your prenatal care covered by (check all that apply):
Health Insurance/HMO ☐ Medicaid ☐ other Health Insurance (Military, Indian Health, etc.) ☐ No Coverage ☐

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.) ☐ Yes/Sí
Me interesa hacer un reviso para el programa Comienzo Saludable. Comprendo que esta informacion se mantiene confidencialmente. Al contestar que sí, favor de contestar las siquientes preguntas. ☐ No

Signature of Patient/Guardian (Firma del cliente o guardian) _____ Date (Fecha) _____

	Yes	No	
1.	☐	☐	1. Do you have any problems which prevent you from keeping your health care or social services appointments?
2.	☐	☐	2. Have you moved more than 3 times in the last 12 months?
3.	☐	☐	3. Do you feel unsafe where you live?
4.	☐	☐	4. Do you or any member of your household go to bed hungry?
5.	☐	☐	5. In the last 2 months, have you used any form of tobacco?
6.	☐	☐	6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?
7.	☐	☐	7. In the last year, has anyone hit you or tried to hurt you?
8.	a b	c	8. How do you rate your current stress level? (a) low, (b) medium, (c) high
9.	a b c	d	9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change

PATIENT STOP HERE

PROVIDER

SECTION 2: BY PROVIDER

	Yes	No	N/A	
10.	☐	☐	☐	10. 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?
11.	☐	☐		11. Does patient have any illness that requires continuing medical care? Specify illness _____

Name and Title of Health Care Provider	Provider's ID	Provider's Phone Number
Provider's Mailing Address	City or Town	Zip Code	County Where Practice is Located

☐ CPHU Provider ☐ HRS Contracted Provider ☐ Private Provider | LMP (mo,day,year) | EDD (mo,day,year) | Trimester of pregnancy at first prenatal visit _____

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight _____

Healthy Start Screening Score: _____
☐ Invited to participate in Healthy Start Care Coordination:
☐ based on score
☐ based on factors other than score
☐ Not referred for Healthy Start Care Coordination

I have explained the patient's Healthy Start screening score and status for Healthy Start Care Coordination.

Provider/Interviewer's Signature and Title _____ Date _____

CONSENT

SECTION 3

I accept the invitation to participate in Florida's Healthy Start. If yes, or maybe, I give permission for my information to be used for care coordination. I understand that this information will be held strictly confidential. ☐ Yes/Sí
Acepto la invitación a participar en el programa Comienzo Saludable. Al marcar sí o quizá doy mi permiso que la información sea utilizado para coordinar mi cuidado. Comprendo que esta información se mantendrá estrictamente confidencial. ☐ No ☐ Maybe/Quizá

Signature of Patient/Guardian (Firma del cliente o guardian) _____ Date (Fecha) _____

To be completed by Health Professional

A<18 (1)
A>39 (1)
RB (2)
MN (1)
EN (1)
W<110 (1)
1Y (1)
2Y (1)
3Y (1)
4Y (1)
5Y (1)
6Y (1)
9C (1)
10Y (1)
11Y (1)
=2T (1)

HRS-H Form 3134, Jun 94
(Obsoletes previous editions which may not be used)
(Stock Number: 5744-100-3134-7)

Distribution of Copies:
WHITE & YELLOW - To County Public Health Unit 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

PATIENT

DEMOGRAPHIC INFORMATION

SECTION 1: COMPLETED BY PATIENT

Your name First	Last	Your County	Todays Date (month, day, year)

Your street address (apartment number):	Your city or town:	Your state:	Your zip code:
Your mailing address (if different from street address):	**Your city or town:**	**Your state:**	**Your zip code:**

Your home phone:	Your work phone or other:	Your birthdate (month, day, year):	Your age:	Your social security number:	Your race: black ☐ white ☐ other ☐

Are you married? yes ☐ no ☐	Have you graduated from high school or received a GED? yes ☐ no ☐	When you were born did you weigh 5½ pounds or less? yes ☐ no ☐ don't know ☐

Your weight before pregnancy:	Your Height: ft. in.	Is this your first pregnancy? If no, give date (month, year) your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). yes ☐ no ☐ Date: _____

Is your prenatal care covered by (check all that apply):
Health Insurance/HMO ☐ Medicaid ☐ Other Health Insurance (Military, Indian Health, etc.) ☐ No Coverage ☐

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) ☐ Yes/Sí ☐ No
Me interesa hacer un reviso para el programa Comienzo Saludable. Comprendo que esta informacion se mantiene confidencialmente. Al contestar que sí, favor de contestar las siquientes preguntas.

_____ Signature of Patient/Guardian (Firma del cliente o guardian)

_____ Date (Fecha)

	Yes	No		
1.	☐	☐	1. Do you have any problems which prevent you from keeping your health care or social services appointments?	1Y (1)
2.	☐	☐	2. Have you moved more than 3 times in the last 12 months?	2Y (1)
3.	☐	☐	3. Do you feel unsafe where you live?	3Y (1)
4.	☐	☐	4. Do you or any member of your household go to bed hungry?	4Y (1)
5.	☐	☐	5. In the last 2 months, have you used any form of tobacco?	5Y (1)
6.	☐	☐	6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?	6Y (1)
7.	☐	☐	7. In the last year, has anyone hit you or tried to hurt you?	
8.	a☐ b☐ c☐		8. How do you rate your current stress level? (a) low, (b) medium, (c) high	
9.	a☐ b☐ c☐ d☐		9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change	9C (1)

PATIENT STOP HERE

PROVIDER

SECTION 2: BY PROVIDER

	Yes	No	N/A		
10.	☐	☐	☐	10. 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?	10Y (1)
11.	☐	☐		11. Does patient have any illness that requires continuing medical care? Specify illness _____	11Y (1)

Name and Title of Health Care Provider		Provider's ID	Provider's Phone Number
Provider's Mailing Address	**City or Town**	**Zip Code**	**County Where Practice is Located**

☐ CHD Provider ☐ DOH Contracted Provider ☐ Private Provider	LMP (mo,day,year)	EDD (mo,day,year)	Trimester of pregnancy at first prenatal visit _____

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight _____ =2T (1)

Healthy Start Screening Score_____
☐ Invited to participate in Healthy Start Care Coordination
☐ based on score
☐ based on factors other than score. Specify _____
☐ Not referred for Healthy Start Care Coordination

I have explained the patient's Healthy Start screening score and status for Healthy Start Care Coordination.

_____ Provider/Interviewer's Signature and Title

_____ Date

CONSENT

SECTION 3

I accept the invitation to participate in Florida's Healthy Start. If yes, or maybe, I give permission for my information to be used for care coordination. I understand that this information will be held strictly confidential. ☐ Yes/Sí ☐ No ☐ Maybe/Quizá

Acepto la invitación a participar en el programa Comienzo Saludable. Al marcar sí o quizá doy mi permiso que la información sea utilizado para coordinar mi cuidado. Comprendo que esta información se mantendrá estrictamente confidencial.

_____ Signature of Patient/Guardian (Firma del cliente o guardian)

_____ Date (Fecha)

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

To be completed by Health Professional
A<18 (1)
A>39 (1)
RB (2)
MN (1)
EN (1)
W<110 (1)

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

SECTION 1: COMPLETED BY PATIENT

Your name: First	Last	M.I.	Your County:	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):	Your city or town:	Your state:	Your zip code:

To be completed by Health Professional

Your home phone:	Your work phone or other:	Your birthdate (month, day, year):	Your age:	Your social security number:	Your race: black ☐ white ☐ other ☐

A<18 (1) A>39 (1) RB (2) MN **T** (1) PHN T

Are you married? yes ☐ no ☐

Have you graduated from high school or received a GED? yes ☐ no ☐

When you were born, did you weigh 5½ pounds or less? yes ☐ no ☐ don't know ☐

Your weight before pregnancy: lbs.	Your Height: ft. in.	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.)☐ No Coverage ☐

EN T (1) W<110 (1)

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.

Yes **No** (initials)

___ 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)	
1.	☐	☐		1.	Do you have any problems which prevent you from keeping your health care or social services appointments?
2.	☐	☐		2.	Have you moved more than 3 times in the last 12 months?
3.	☐	☐		3.	Do you feel unsafe where you live?
4.	☐	☐		4.	Do you or any member of your household go to bed hungry?
5.	☐	☐		5.	In the last 2 months, have you used any form of tobacco?
6.	☐	☐		6.	In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?
7.	☐	☐		7.	In the last year, has anyone hit you or tried to hurt you?
8.	a☐b☐c☐			8.	How do you rate your current stress level? (a) low, (b) medium, (c) high
9.	a☐b☐c☐	d☐		9.	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.	☐	☐		10.	Have you considered adoption for this pregnancy?
11.	☐	☐		11.	Do you now, or have you ever had, problems with depression?
12.	☐	☐		12.	Do you have a history of receiving mental health counseling?
13.	☐	☐	☐	13.	Is your partner unemployed?

1Y (1) 2Y T (1) 3Y (1) 4Y (1) 5Y (1) 6Y T (1) 7Y T 8C T 9C **T** (1) 10Y T 11Y T 12Y T 13Y T

Yes **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)**

SECTION 2: BY PROVIDER

	Yes	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 the hospital after the patient went home?
15.	☐	☐		15.	Does patient have any illness that requires continuing medical care? Specify illness: _____

14Y (1) 15Y (1)

Name and Title of Health Care Provider:	Provider's ID:	Provider's Phone Number:

Provider's Mailing Address:	City or Town:	Zip Code:	County Where Practice is Located:

☐ CHD Provider ☐ DOH Contracted Provider ☐ Private Provider	LMP (mo,day,year)	EDD (mo,day,year)	Trimester of pregnancy at first prenatal visit:

=2T (1)

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight (less than 5½ pounds)_____

2 or 3T **T**

Healthy Start Screening Score	CHECK ONE	
		☐ **Invited to participate in Healthy Start based on score.**
		☐ **Invited to participate in Healthy Start based on factors other than score. Specify :** _____
		☐ **Not referred for Healthy Start.**

I have explained the Healthy Start program, and if screened, the screening score.

_____ _____

Provider's/Interviewer's Signature and Title **Date (mm/dd/yy)**

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

DH 3134, 2/01 stock number 5744-100-3134-7

Distribution of copies: WHITE & YELLOW - County Health Department in county where screening occurred
PINK - Retained in patient's record GREEN - Patient's Copy

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.

SECTION 1: COMPLETED BY PATIENT

Name: First	Last	M.I.	County:	Today's Date (month/day/year):

Census Tract (local use)

Street address (apartment complex name/number):	City or town:	State:	Zip code:

Mailing address (if different from street address):	City or town:	State:	Zip code:

To be completed by Health Professional

Home phone:	Work phone or other:	Date of Birth (mo/day/yr):	Age:	Social security number:	Race: black ❑ white ❑ other ❑

A<18 (1)
A>39 (1)
RB (2)

Are you married? yes ❑ no ❑	Have you graduated from high school or received a GED? yes ❑ no ❑	When you were born, did you weigh 5½ pounds or less? yes ❑ no ❑ don't know ❑

MN T (1)
PHN T

Weight before pregnancy: lbs.	Height: ft. in.	Is this your first pregnancy? yes ❑ no ❑ If no, give date your last pregnancy ended (include live birth, stillbirth, miscarriage, abortion). Date: (month/year)_____

Is your prenatal care covered by:
Health Insurance/HMO ❑ _____ Medicaid ❑ Other Health Insurance (Military, Indian Health, etc.) ❑ _____ No Coverage ❑

EN T (1)
W<110 (1)

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.

	Yes	No	N/A	(please check appropriate box)	
1.	❑	❑		1. Do you have any problems that prevent you from keeping your health care or social services appointments?	1Y (1)
2.	❑	❑		2. Have you moved more than 3 times in the last 12 months?	2Y T (1)
3.	❑	❑		3. Do you feel unsafe where you live?	3Y (1)
4.	❑	❑		4. Do you or any member of your household go to bed hungry?	4Y (1)
5.	❑	❑		5. In the last 2 months, have you used any form of tobacco?	5Y (1)
6.	❑	❑		6. In the last 2 months, have you used drugs or alcohol (including beer, wine, mixed drinks)?	6Y T (1)
7.	❑	❑		7. In the last year, has anyone hit you or tried to hurt you?	7Y T
8.	a❑	b❑	c❑	8. How do you rate your current stress level? (a) low, (b) medium, (c) high	8C T
9.	a❑	b❑	c❑ d❑	9. If you could change the timing of this pregnancy, would you want it (a) earlier, (b) later, (c) not at all, (d) no change	9C **T** (1)
10.	❑	❑		10. Have you considered adoption for this pregnancy?	10Y T
11.	❑	❑		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.	❑	❑	❑	13. Is your partner unemployed?	13Y T

Yes_ **No**_ **(please initial)** If I am referred, Healthy Start may contact me.
The best time to contact me is: _____

Yes_____ **No**_____ **(please initial)** By initialing yes, I am giving my written permission for release of the confidential information on this form and any information provided during my evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims 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 shall remain in effect unless withdrawn in writing.

Signature of patient or guardian _____ **Date (mo/day/yr)** _____

SECTION 2: BY PROVIDER

	Yes	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 the hospital after the patient went home?	14Y (1)
15.	❑	❑		15. Does patient have any illness that requires continuing medical care? Specify illness: _____	15Y (1)

Name and Title of Health Care Provider:	Provider's ID:	Provider's Phone Number:

Provider's Mailing Address:	City or Town:	Zip Code:	County Where Practice is Located:

❑ CHD Provider ❑ DOH Contracted Provider ❑ Private Provider	LMP (mo/day/yr)	EDD (mo/day/yr)	Trimester of pregnancy at 1st prenatal visit:

=2T (1)
2 or 3T **T**

Previous Obstetrical History: Enter the number of infants in each area. (Use zero for none.)
Term _____ Preterm _____ Abortion _____ Living _____ Low Birth Weight (less than 5½ pounds)_____

Healthy Start Screening Score _____	CHECK ONE	❑ Referred to Healthy Start based on score. ❑ Referred to Healthy Start based on factors other than score. Specify: _____ ❑ Not referred to Healthy Start or Patient declined Healthy Start.

I have explained the Healthy Start program, and if screened, the patient's screening score.

Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

DH 3134, 01/04 stock number 5744-100-3134-7

Distribution of copies: WHITE & YELLOW - County Health Department in county where screening oc
PINK - Retained in patient's record GREEN - Patient's Copy

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 confidential. 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.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐1
2. Are you married now?	☐	☐1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☐1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
☐ White ☐3 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be…….?
☐ pregnant now ☐ pregnant later ☐1 not pregnant

15. Is this your first pregnancy?
☐2 Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.
☐3 Had a baby that was not born alive
☐ Had a baby born 3 weeks or more before due date
☐3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age: ☐1 <18
Street address (apartment complex name/number):	County:	City: State:	Zip Code:
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

✶ *If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐1 < 19.8 ☐2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐2 Yes
Healthy Start Screening Score: _____	**Check One: ☐ Referred to Healthy Start. If score <6, specify:_____ ☐ Not Referred to Healthy Start.**		

Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)**_____

DH 3134, 04/08, stock number 5744-1100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred PINK—Retained in patient's record GREEN—Patient's Copy