PRENATAL - EARLY HEAD START HEALTH COVER SHEET

EXPECTANT MOTHER'S NAME:	**DOB:**

CENTER:	**FW/HV:**

ENROLLMENT DATE:

1. EXPECTED DUE DATE:	**TRIMESTER:**

HAVE YOU RECEIVED PRENATAL CARE? YES* NO (Refer)
*If yes, in which month of your pregnancy? _____ Month

2. COMPREHENSIVE PRENATAL CARE PROVIDER: _____
(If none, refer to MD & SHS RD)

3. Prenatal Visits

Date	Provider	Concerns	Follow Up	High Risk	
				Yes	No
				Yes	No
				Yes	No
				Yes	No

4. WIC Provider

Date	Concerns	Follow Up

5. Dental

Date Completed:	Follow Up Needed:

6. Actual Delivery Date:

7. PostPartum Visits with Health Care Provider

Date:	Comments:
Date:	Comments:

8. 2 Week Newborn Visit By EHS Staff/Consultants

Date:	By:	Comments:
Date:	By:	Comments:

9. Prenatal Education	**Date Completed**
Prenatal/PostPartum Health Care	
Mental Health Intervention	
Substance Abuse Prevention and Treatment	
Prenatal Education on Fetal Development	
Information on the Benefits of Breastfeeding	
Nutrition Packet	
Other	