

Ohio Department of Health • Bureau of Child and Family Health Services
Perinatal Health MATCH-IPHS Form¹

Complete Name, SSN OR CFHS client # at each encounter

Name (Last, First, Middle Initial)		Birth date (MM/DD/YYYY)	Social Security #	CFHS Client #
Date of Encounter ____/____/____ (MM/DD/YYYY)	Home Visit <input type="checkbox"/>	Site letter: _____	WIC Participant <input type="checkbox"/> Yes <input type="checkbox"/> No, Referred <input type="checkbox"/> No, Not Referred	HMG Participant <input type="checkbox"/> Yes <input type="checkbox"/> No, Referred <input type="checkbox"/> No, Not Referred
Principal source of payment for this encounter (check only one):				
<input type="checkbox"/> A. Health insurance through Private insurance current or former employer or union.		<input type="checkbox"/> D. Purchased directly		
<input type="checkbox"/> B. Other Government (Specify, e.g., Indian Health Service, Other Government (federal, state, local))		<input type="checkbox"/> E. Other _____		
<input type="checkbox"/> C. Medicaid		<input type="checkbox"/> F. Uninsured		
		<input type="checkbox"/> H. CHAMPUS/TRICARE		
If uninsured/underinsured, indicate status (check one)				
<input type="checkbox"/> A. CPA completed		<input type="checkbox"/> B. Medicaid eligibility pending		<input type="checkbox"/> C. Medicaid ineligible <input type="checkbox"/> D. Client refused Medicaid

Complete Sections 1-7 at each encounter. Check all that apply.

1. Type of Encounter		<input type="checkbox"/> A. Direct Care	<input type="checkbox"/> B. Enabling (Complete #8 also)	<input type="checkbox"/> C. Direct Care & Enabling (Complete #8 also)
2. Purpose of Encounter		<input type="checkbox"/> A. Antepartum	<input type="checkbox"/> B. Postpartum (Complete #9 also)	
3. Risk factors in this pregnancy (Check all that apply):				
<input type="checkbox"/> A. None		<input type="checkbox"/> I. Pregnancy resulted from assisted reproductive technology		<input type="checkbox"/> P. Nutrition/Weight-Related problems
<input type="checkbox"/> B. Pre-pregnancy diabetes		<input type="checkbox"/> J. Mother had a previous cesarean delivery		<input type="checkbox"/> Q. Current pregnancy-related complications
<input type="checkbox"/> C. Gestational diabetes		If Yes, how many _____		<input type="checkbox"/> R. Pregnancy test Positive?
<input type="checkbox"/> D. Pre-pregnancy hypertension (chronic)		<input type="checkbox"/> K. Anemia (Hct. 30/Hgb. <10)		<input type="checkbox"/> S. Pregnancy test Negative?
<input type="checkbox"/> E. Gestational hypertension without eclampsia		<input type="checkbox"/> L. Cardiac Disease		<input type="checkbox"/> T. Other (specify) _____
<input type="checkbox"/> F. Eclampsia		<input type="checkbox"/> M. Acute or Chronic Lung Disease		<input type="checkbox"/> U. Unknown
<input type="checkbox"/> G. Other previous poor pregnancy outcome		<input type="checkbox"/> N. Hydramnios/Oligohydramnios		
<input type="checkbox"/> H. Pregnancy resulted from fertility-enhancing drugs, artificial insemination or intrauterine insemination		<input type="checkbox"/> O. Hemoglobinopathy		
4. Infections present and/or treated during this pregnancy (Check all that apply):				
<input type="checkbox"/> A. None		<input type="checkbox"/> I. HIV- mother received antiretroviral therapy		<input type="checkbox"/> Q. Syphilis
<input type="checkbox"/> B. Bacterial Vaginosis		<input type="checkbox"/> J. HIV- mother did NOT receive antiretroviral therapy		<input type="checkbox"/> R. Trichomoniasis
<input type="checkbox"/> C. Chlamydia		<input type="checkbox"/> K. In Utero Infection (TORCHS)		<input type="checkbox"/> S. Toxoplasmosis
<input type="checkbox"/> D. CMV		<input type="checkbox"/> L. Maternal Group B Strep Colonization		<input type="checkbox"/> T. Varicella
<input type="checkbox"/> E. Gonorrhea		<input type="checkbox"/> M. Measles		<input type="checkbox"/> U. Other (specify-optional) _____
<input type="checkbox"/> F. Hepatitis B (HBsAg-positive ____/____/____)		<input type="checkbox"/> N. Mumps		<input type="checkbox"/> V. Unknown
<input type="checkbox"/> G. Hepatitis C		<input type="checkbox"/> O. PID		
<input type="checkbox"/> H. Herpes Simplex Virus		<input type="checkbox"/> P. Rubella		
5. Social/Behavioral Risk Factors (Check all that apply.)				
<input type="checkbox"/> A. None at this Encounter		<input type="checkbox"/> F. Mental Retardation/Mental Illness		
<input type="checkbox"/> B. Alcohol Use - How many alcoholic beverages do you consume on a typical day?		<input type="checkbox"/> G. Second-Hand Smoke		
If you NEVER drink, enter "0": # of drinks _____ per day		<input type="checkbox"/> H. Smoking - How many cigarettes OR packs of cigarettes do you smoke on a typical day? If you NEVER smoke, enter zero (0).		
<input type="checkbox"/> C. Domestic Violence		# of cigarettes _____ OR # of packs _____		
<input type="checkbox"/> D. Drug Use		<input type="checkbox"/> I. Other (specify-optional) _____		
<input type="checkbox"/> E. Inadequate Social/Economic Support				
6. Professionals providing services (Check all that apply.)				
<input type="checkbox"/> A. RN		<input type="checkbox"/> D. Certified Nurse-Midwife	<input type="checkbox"/> G. Licensed Social Worker/Counselor	<input type="checkbox"/> J. Outreach Worker
<input type="checkbox"/> B. LPN		<input type="checkbox"/> E. Nursing/Medical Assistant	<input type="checkbox"/> H. Licensed/Registered Dietitian	<input type="checkbox"/> K. Other (specify) _____
<input type="checkbox"/> C. Nurse Practitioner		<input type="checkbox"/> F. Physician	<input type="checkbox"/> I. Health Educator	
7. Referral services made for client (Check all that apply.)				
<input type="checkbox"/> None at this Encounter		<input type="checkbox"/> D. Family Planning		<input type="checkbox"/> H. Counseling
<input type="checkbox"/> A. Oral Health		<input type="checkbox"/> E. High Risk Perinatal		<input type="checkbox"/> I. Social Service
<input type="checkbox"/> B. Diagnostic		<input type="checkbox"/> F. Hospital		<input type="checkbox"/> J. Other (specify-optional) _____
<input type="checkbox"/> C. Drug/Alcohol Abuse		<input type="checkbox"/> G. Nutrition		
8. Type of Enabling Service (Enter # of minutes spent on each activity) Complete sections 8-9 when applicable.				
A. Assessment/Counseling -- Medical Risk.....		F. Care Coordination.....		
B. Assessment/Counseling -- Social/Behavioral		G. CPA Assistance.....		
C. Assessment/Counseling -- Nutrition.....		H. Transportation Assistance.....		
D. Assessment/Counseling -- Other (Specify Mandatory)		I. Translation Services.....		
E. Education (individual or group).....		J. Smoking Treatment Program (formal).....		
		K. Other (Specify Mandatory).....		
9. Postpartum Issues				
A. Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		C. Birth Control Chosen <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
B. Postpartum Depression <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		D. Currently Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Local Use Only 1. _____ 2. _____				

¹ Revised 12/20/07.

Complete questions 10-17 at the FIRST ENCOUNTER of each pregnancy ONLY.

Date of First Encounter ___ / ___ / _____ (MM/DD/YYYY)

10. Intendedness

- A. The client wanted to be pregnant sooner
 B. The client wanted to be pregnant later
 C. The client wanted to be pregnant then
 D. The client did not want to be pregnant then or at any time in the future

11. Number of previous pregnancies _____ Date of last live birth/other pregnancy outcome: ___ / ___ / _____ (MM/DD/YYYY)

12. Weeks gestation at time of admission to clinic: _____

13. If prenatal care began prior to this encounter, record weeks gestation when care began. _____

14. Expected Date of Confinement ___ / ___ / _____ (MM/DD/YYYY)

15. Risk status (Check only one based on ODJFS Prenatal Risk Assessment Form)

- A. No Risk
 B. Previous Pre-term
 C. Poor Outcome
 D. Both Pre-term and Poor Outcome

16. Does client have any pre-existing chronic conditions?

- Yes No

17. Weight-Related Risk Conditions (Check only one)

- A. No Risk
 B. Underweight (<90% standard wt/ht)
 C. Overweight (120-134% standard wt/ht)
 D. Obese (≥135% standard wt/ht)

Complete sections 18-21 at the END OF PRENATAL CARE (only to be filled out if pregnancy termination occurs or out of state prenatal care is sought).

18. How many cigarettes OR packs of cigarettes did you smoke on a typical day during each of the following time periods? If you NEVER smoked, enter zero (0) for each time period.

	# of cigarettes	OR	# of packs
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Third trimester of pregnancy	_____	OR	_____

19. Pregnancy Outcome Information (Check only one)

- A. Delivered (If delivered, select one of the following below):
 Live Birth
 Neonatal Death
 Post-neonatal Death
 Delivered - Unknown
 B. Elective Abortion
 C. Spontaneous Abortion
 D. Fetal Death
 E. Lost to Follow Up
 F. Delivered - Unknown

20. Birth Information

Method of Delivery

Delivery Type Vaginal Cesarean Unknown

Special Care Yes No Unknown

Multiple Birth Yes No Unknown

Plurality (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.) (Include all live births and fetal losses resulting from this pregnancy.): _____

Date of Birth ___ / ___ / _____ (MM/DD/YYYY) Unknown

Obstetric estimate of gestation at delivery (completed weeks): _____ Unknown

Birth weight: _____ (grams) (Do not convert lb/oz to grams)

If weight in grams is not available, birth weight: _____ (lb/oz)

Facility I.D. (National Provider Identifier): _____

21. Baby's Legal Name

First _____ Middle _____ Last _____ Suffix _____