

Patient Name: _____

☐ First Pregnancy☐ Medicaid

Age: _____ GSA: _____ Weeks

Perinatal Navigation At-Risk Qualifier Questionnaire			
#	Question	Patient Information	# Gray
1	What is your current employment status?	<input type="checkbox"/> Unemployed	
		<input type="checkbox"/> Part Time	
		<input type="checkbox"/> Full Time	
		<input type="checkbox"/> Other _____	
2	What is your relationship status?	<input type="checkbox"/> Single	
		<input type="checkbox"/> Married	
		<input type="checkbox"/> Other _____	
3	What is your current housing situation?	<input type="checkbox"/> Homeless (Including Transient*)	
		<input type="checkbox"/> Apartment/House	
		<input type="checkbox"/> Other _____	
4	What is your highest level of education completed?	<input type="checkbox"/> Some High School Education <i>Currently in HS or did not Complete HS</i>	
		<input type="checkbox"/> High School Diploma/GED	
		<input type="checkbox"/> Some College	
		<input type="checkbox"/> College Diploma	
		<input type="checkbox"/> Other _____	
5	Do you actively use any substances that can be harmful to your growing baby?	<input type="checkbox"/> None	
		<input type="checkbox"/> Cigarettes	
		<input type="checkbox"/> Alcohol	
		<input type="checkbox"/> Illegal Drugs	
		<input type="checkbox"/> Other _____	
6	Do you have any significant pregnancy history?	<input type="checkbox"/> First pregnancy	
		<input type="checkbox"/> Past miscarriage(s)	
		<input type="checkbox"/> NICU Baby due to Substance Abuse	
		<input type="checkbox"/> History of Postpartum Depression or Anxiety	
		<input type="checkbox"/> Other _____	
7	Do you have any financial stressors? <small>*Any number of checked indicators counts as one in final column</small>	<input type="checkbox"/> Difficulty paying the bills	
		<input type="checkbox"/> Difficulty putting food on the table	
		<input type="checkbox"/> Difficulty clothing your children	
		<input type="checkbox"/> Difficulty providing basic hygiene items	
		<input type="checkbox"/> Difficulty finding transportation	
		<input type="checkbox"/> Other _____	
8	Are there any safety concerns in your home?	<input type="checkbox"/> None	
		<input type="checkbox"/> Current or previous DCS case	
		<input type="checkbox"/> Incarcerated	
		<input type="checkbox"/> Other _____	
9	Post-Partum Infant Risk Qualifiers	<input type="checkbox"/> Positive Toxicology	
		<input type="checkbox"/> NICU Admission	
		<input type="checkbox"/> Low Birth Weight	
		<input type="checkbox"/> Father NOT listed on Birth Certificate	
		<input type="checkbox"/> Inconsistent or Late (only 3 rd Trimester) Prenatal Care	
		<input type="checkbox"/> No Prenatal Care	
ANY BLACK INDICATOR IS AUTOMATIC QUALIFICATION			
Navigation At-Risk Score Total Gray Historically a Total Score ≥ 4 qualifies a patient as At-Risk and a candidate for RES Program			
<small>*Transient status: An individual with no permanent living arrangement. "A person who stays with a succession of friends or relatives and has no permanent living arrangement on the first moment of the month." -SOAR, HUD, SSA</small>			