



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?	<input type="checkbox"/>	<input type="checkbox"/> ₁
2. Are you married now?	<input type="checkbox"/>	<input type="checkbox"/> ₁
3. Are there any children at home younger than 5 years old?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are there any children at home with medical or special needs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is this a good time for you to be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last month, have you felt down, depressed or hopeless?	<input type="checkbox"/> ₁	<input type="checkbox"/>
7. In the last month, have you felt alone when facing problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever received mental health services or counseling?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the last year, has someone you know tried to hurt you or threaten you?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble paying your bills?	<input type="checkbox"/>	<input type="checkbox"/>

11. What race are you? Check one or more.

White Black Other _____

12. In the last month, how many alcoholic drinks did you have per week?

_____ drinks ₁ did not drink

13. In the last month, how many cigarettes did you smoke a day? (a pack has 20 cigarettes)

_____ cigarettes ₁ 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

₃ 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: _____ <input type="checkbox"/> ₁ < 18
Street address (apartment complex name/number): _____	County: _____	City: _____ State: _____	Zip Code: _____
Prenatal Care covered by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> 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: _____	<input type="checkbox"/> ₁ < 19.8 <input type="checkbox"/> ₂ > 35.0
Provider's Name: _____	Provider's ID: _____	19. Pregnancy Interval Less Than 18 Months? <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> ₁ Yes
Provider's Phone Number: _____	Provider's County: _____	20. Trimester at 1st Prenatal Visit? _____	<input type="checkbox"/> ₁ 2nd
Healthy Start Screening Score: _____	Check One: <input type="checkbox"/> Referred to Healthy Start. If score <6, specify: _____ <input type="checkbox"/> Not Referred to Healthy Start.		
Provider's/Interviewer's Signature and Title _____		Date (mo/day/yr) _____	



PROVIDER INSTRUCTIONS FOR COMPLETING THE PRENATAL SCREEN

For translation help, or help in locating substance abuse treatment, call the Family Health Line 1-800-451-2229.

Please note that the form is to be signed by the patient. Please review for completion prior to forwarding all screening forms (white and yellow copies) to the county health department in the county where screening occurred.

FIRST STEP:

1. See instructions on the back of the green copy (patient copy) of the form.
2. If the patient would like to participate in the screening process, the patient should complete questions 1-16, the patient information section and the consent statements with signature and date and the provider should complete the provider section.
 - **Question 9:** If the patient answers "yes", make the appropriate referral based on Domestic Violence services available in your community.
 - **Question 18:** Use the BMI chart on the back of the yellow copy to determine the patients BMI score based on height and weight information. If the patient's BMI score is less than 19.8 or greater than 35, check the box of the appropriate response.
 - **Question 19:** If the patient answered "no" to Question 15, provide a date and the date is less than 18 months before the current pregnancy, check yes. If the date the patient provided in Question 15 is greater than 18 months or the patient answered "yes" to Question 15, check "no".
 - **Question 20:** Enter the trimester at which the patient had her first prenatal visit. If the patient entered prenatal care in the second trimester, check "2nd".
 - **Question 21:** Check "yes" if patient requires ongoing medical care and specify the condition or diagnosis.
3. Complete the name of the Physician, Certified Nurse Midwife, or Advanced Registered Nurse Practitioner providing the prenatal care. Also complete the provider I.D. (the number established by the county for each provider), phone number, and county for the prenatal healthcare office.

SECOND STEP:

1. Determine the patient's Healthy Start screening score. Along side of the check boxes for individual risk factors is a subscribed number, which is the number of Healthy Start points assigned to that risk item. Circle the corresponding check box and point value for risk factors based on responses to specific questions. Add the circled points. This total is the patient's Healthy Start screening score and is entered in the space indicated.
2. Refer the patient for participation in Healthy Start care coordination if (a) the prenatal screening score is six or more, or (b) the patient is at risk for an adverse outcome based on factors other than score, including maternal illness, homelessness, domestic violence, HIV status, substance abuse, or other factors that Healthy Start care coordination and risk appropriate services might reduce. Check the appropriate box to indicate referral status. Discuss the Healthy Start screening score and status for care coordination with the patient. Sign and date the form.
3. Please note that the form is to be signed by the patient. Please review for completion prior to forwarding all screening forms (white and yellow copies) to the county health department in the county where screening occurred. Keep the pink copy in the patient's medical record and give the patient the green copy. This documents compliance with s. 383.14, F.S. The demographic data is important to evaluate Healthy Start and must be completed.

IF PATIENT DECLINES PARTICIPATION IN SCREENING:

1. If the patient signs the decline statement under the patient information section of the form, ask the patient to fill in demographic information, and sign and date the form below the statement denoted with an asterisk* located just above the provider section. Except for provider identification information and signature, the remainder of the form is not completed. If the patient refuses to sign the form, write "patient refuses to sign" on the form. Assure the patient that she will continue to receive care.
2. Send the screening form (white and yellow copies) to the county health department in the county where the attempted prenatal screening occurred.

DEFINITIONS

EDD: is the Estimated Date of Delivery based on clinical judgment.

LMP: is the date the patient indicates she began her last menstrual period (enter month and year even if day is unavailable).

Trimester of pregnancy at first prenatal visit: is the trimester based on her LMP when the patient first received prenatal care (even if that care was elsewhere).

1st Trimester: 1st day of LMP through 13th week

2nd Trimester: 1st day of 14th week through 26th week

3rd Trimester: 1st day of 27th week through 42nd week

Body Mass Index Chart

BMI	Height (in)																		
	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76
Wgt. (lbs)	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
100	20.9	20.2	19.5	18.9	18.3	17.7	17.2	16.6	16.1	15.7	15.2	14.8	14.3	13.9	13.6	13.2	12.8	12.5	12.2
105	21.9	21.2	20.5	19.8	19.2	18.6	18.0	17.5	16.9	16.4	16.0	15.5	15.1	14.6	14.2	13.9	13.5	13.1	12.8
110	23.0	22.2	21.5	20.8	20.1	19.5	18.9	18.3	17.8	17.2	16.7	16.2	15.8	15.3	14.9	14.5	14.1	13.7	13.4
115	24.0	23.2	22.5	21.7	21.0	20.4	19.7	19.1	18.6	18.0	17.5	17.0	16.5	16.0	15.6	15.2	14.8	14.4	14.0
120	25.1	24.2	23.4	22.7	21.9	21.3	20.6	20.0	19.4	18.8	18.2	17.7	17.2	16.7	16.3	15.8	15.4	15.0	14.6
125	26.1	25.2	24.4	23.6	22.9	22.1	21.5	20.8	20.2	19.6	19.0	18.5	17.9	17.4	17.0	16.5	16.0	15.6	15.2
130	27.2	26.3	25.4	24.6	23.8	23.0	22.3	21.6	21.0	20.4	19.8	19.2	18.7	18.1	17.6	17.1	16.7	16.2	15.8
135	28.2	27.3	26.4	25.5	24.7	23.9	23.2	22.5	21.8	21.1	20.5	19.9	19.4	18.8	18.3	17.8	17.3	16.9	16.4
140	29.3	28.3	27.3	26.4	25.6	24.8	24.0	23.3	22.6	21.9	21.3	20.7	20.1	19.5	19.0	18.5	18.0	17.5	17.0
145	30.3	29.3	28.3	27.4	26.5	25.7	24.9	24.1	23.4	22.7	22.0	21.4	20.8	20.2	19.7	19.1	18.6	18.1	17.6
150	31.3	30.3	29.3	28.3	27.4	26.6	25.7	25.0	24.2	23.5	22.8	22.1	21.5	20.9	20.3	19.8	19.3	18.7	18.3
155	32.4	31.3	30.3	29.3	28.3	27.5	26.6	25.8	25.0	24.3	23.6	22.9	22.2	21.6	21.0	20.4	19.9	19.4	18.9
160	33.4	32.3	31.2	30.2	29.3	28.3	27.5	26.6	25.8	25.1	24.3	23.6	23.0	22.3	21.7	21.1	20.5	20.0	19.5
165	34.5	33.3	32.2	31.2	30.2	29.2	28.3	27.5	26.6	25.8	25.1	24.4	23.7	23.0	22.4	21.8	21.2	20.6	20.1
170	35.5	34.3	33.2	32.1	31.1	30.1	29.2	28.3	27.4	26.6	25.8	25.1	24.4	23.7	23.1	22.4	21.8	21.2	20.7
175	36.6	35.3	34.2	33.1	32.0	31.0	30.0	29.1	28.2	27.4	26.6	25.8	25.1	24.4	23.7	23.1	22.5	21.9	21.3
180	37.6	36.4	35.2	34.0	32.9	31.9	30.9	30.0	29.0	28.2	27.4	26.6	25.8	25.1	24.4	23.7	23.1	22.5	21.9
185	38.7	37.4	36.1	35.0	33.8	32.8	31.8	30.8	29.9	29.0	28.1	27.3	26.5	25.8	25.1	24.4	23.8	23.1	22.5
190	39.7	38.4	37.1	35.9	34.7	33.7	32.6	31.6	30.7	29.8	28.9	28.1	27.3	26.5	25.8	25.1	24.4	23.7	23.1
195	40.8	39.4	38.1	36.8	35.7	34.5	33.5	32.4	31.5	30.5	29.6	28.8	28.0	27.2	26.4	25.7	25.0	24.4	23.7
200	41.8	40.4	39.1	37.8	36.6	35.4	34.3	33.3	32.3	31.3	30.4	29.5	28.7	27.9	27.1	26.4	25.7	25.0	24.3
205	42.8	41.4	40.0	38.7	37.5	36.3	35.2	34.1	33.1	32.1	31.2	30.3	29.4	28.6	27.8	27.0	26.3	25.6	25.0
210	43.9	42.4	41.0	39.7	38.4	37.2	36.0	34.9	33.9	32.9	31.9	31.0	30.1	29.3	28.5	27.7	27.0	26.2	25.6
215	44.9	43.4	42.0	40.6	39.3	38.1	36.9	35.8	34.7	33.7	32.7	31.7	30.8	30.0	29.2	28.4	27.6	26.9	26.2
220	46.0	44.4	43.0	41.6	40.2	39.0	37.8	36.6	35.5	34.5	33.4	32.5	31.6	30.7	29.8	29.0	28.2	27.5	26.8
225	47.0	45.4	43.9	42.5	41.1	39.9	38.6	37.4	36.3	35.2	34.2	33.2	32.3	31.4	30.5	29.7	28.9	28.1	27.4
230	48.1	46.4	44.9	43.5	42.1	40.7	39.5	38.3	37.1	36.0	35.0	34.0	33.0	32.1	31.2	30.3	29.5	28.7	28.0
235	49.1	47.5	45.9	44.4	43.0	41.6	40.3	39.1	37.9	36.8	35.7	34.7	33.7	32.8	31.9	31.0	30.2	29.4	28.6
240	50.2	48.5	46.9	45.3	43.9	42.5	41.2	39.9	38.7	37.6	36.5	35.4	34.4	33.5	32.5	31.7	30.8	30.0	29.2
245	51.2	49.5	47.8	46.3	44.8	43.4	42.0	40.8	39.5	38.4	37.2	36.2	35.2	34.2	33.2	32.3	31.5	30.6	29.8
250	52.2	50.5	48.8	47.2	45.7	44.3	42.9	41.6	40.3	39.2	38.0	36.9	35.9	34.9	33.9	33.0	32.1	31.2	30.4
255	53.3	51.5	49.8	48.2	46.6	45.2	43.8	42.4	41.2	39.9	38.8	37.7	36.6	35.6	34.6	33.6	32.7	31.9	31.0
260	54.3	52.5	50.8	49.1	47.5	46.1	44.6	43.3	42.0	40.7	39.5	38.4	37.3	36.3	35.3	34.3	33.4	32.5	31.6
265	55.4	53.5	51.7	50.1	48.5	46.9	45.5	44.1	42.8	41.5	40.3	39.1	38.0	37.0	35.9	35.0	34.0	33.1	32.3
270	56.4	54.5	52.7	51.0	49.4	47.8	46.3	44.9	43.6	42.3	41.0	39.9	38.7	37.7	36.6	35.6	34.7	33.7	32.9
275	58.1	55.5	53.7	52.0	50.3	48.7	47.1	45.8	44.4	43.1	41.8	40.6	39.5	38.4	37.3	36.3	35.3	34.4	33.5
280	58.5	56.5	54.7	52.9	51.2	49.6	48.1	46.6	45.2	43.8	42.6	41.3	40.2	39.0	38.0	36.9	35.9	35.0	34.1
285	65.3	57.6	55.7	53.8	52.1	50.5	48.9	47.4	46.0	44.6	43.3	42.1	40.9	39.7	38.6	37.6	36.6	35.6	34.7
290	60.6	58.6	56.6	54.8	53.0	51.4	49.8	48.3	46.8	45.4	44.1	42.8	41.6	40.4	39.3	38.3	37.2	36.2	35.3
295	61.6	59.6	57.6	55.7	54.0	52.3	50.6	49.1	47.6	46.2	44.8	43.6	42.3	41.1	40.0	38.9	37.9	36.9	35.9
300	62.7	60.6	58.6	56.7	54.9	53.1	51.5	49.9	48.4	47.0	45.6	44.3	43.0	41.8	40.7	39.6	38.5	37.5	36.5

Calculating the Healthy Start Risk Screen Score:

The subscripted number located to the right check box for each Healthy Start risk factor reflects the number of points assigned to the risk factor. Circle the corresponding number of points for any subscribed check box items selected by the patient in response to questions 1, 2, 6, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21. If the patient's age is less than 18, check the "<18" response box and circle the point. If the patient's body mass index (BMI) is less than 19.8 or greater than 35.0, check the appropriate (<19.8 or >35.0) response and circle the point(s). If the patient's last pregnancy was less than 18 months prior to the date of screening, check the "yes" response box and circle the point. If the trimester of pregnancy at 1st prenatal visit is the 2nd trimester, check the "2nd" response and circle the point. If the patient has an illness that requires ongoing medical care, check the "yes" response and circle the points. **Add the circled points. This total is the patient's Healthy Start screening score and is entered in the space indicated in Section 2 of the form. Healthy Families Florida risk scoring and referral will be determined upon risk screen review by Healthy Families staff with the patient's initialed consent for release of information.**



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!

Today's Date: _____

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

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?

- _____ drinks ₁ did not drink

13. In the last month, how many cigarettes did you smoke a day? (a pack has 20 cigarettes)

- _____ cigarettes ₁ 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
 ₃ 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: <input type="checkbox"/> ₁ <18
Street address (apartment complex name/number): _____	County: _____	City: _____ State: _____	Zip Code: _____
Prenatal Care covered by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> 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.



A Healthy Start for Your Baby... As easy as 1, 2, 3

- Step 1.** Answer questions 1-16 to find out if there are possible concerns that may affect your health or the health of your baby—your answers are kept private.
- Step 2.** Complete the Patient Information Section, sign and date the form.*
- Step 3.** Please initial yes or no to release specific information.

That's all. Your provider will do the rest.

If you are referred by your prenatal healthcare provider, a program representative will contact you to explain the results, answer your question and help you receive the best services available for your needs.

Services may include:

Breastfeeding education, help to reduce stress, help to quit smoking, tips on healthier eating, information on caring for your baby and yourself, help with appointments, new ideas for a healthy lifestyle, childbirth and parenting education and support.

**Per Section 119.071(5)(a)3., the Florida Department of Health is requesting your social security number for purposes of linking population based data for program evaluation”.*

Every baby deserves a healthy start!



Domestic violence may increase during pregnancy. Shelter, counseling and legal aid are available.

Call 1-800-500-1119

For substance abuse treatment, call the Family Health Line.

Call 1-800-451-2229

WIC provides healthy foods to pregnant women and children.

Call 1-800-342-3556

For parenting questions or needs, call the Parent Help Line.

1-800-352-5683