Caring for You Throughout Life

WOMEN'S HEALTH of Central Massachusetts

# Obstetrical Care

Welcome to WHCMA! We are delighted to care for you during your pregnancy and birth.

We provide services at UMass Memorial Hospital, located at 119 Belmont Street in Worcester. Our practice consists of both male and female providers – all very experienced, qualified, and Board-Certified to provide your obstetrical care. We would like to take a moment to explain our coverage arrangement for your obstetrical care. WHCMA has a team of obstetricians and a nurse midwife. The obstetricians share night, weekend, weekday, and vacation coverage. Weekdays, between 8am and 5pm, one of our obstetricians (the "Laborist") remains at UMass Memorial Hospital to cover deliveries. Resident physicians often assist us and are a tremendous help in looking after our patients. We look forward to caring for you during your pregnancy.

By signing below, I acknowledge that any of the individuals listed below may care for me during my experience at the hospital.

_____ _____/_____/_____

Patient's Name (Please Print) Date of Birth

_____ _____/_____/_____

Patient's Signature Date

- **Amy Chang, MD**
- **Christopher Conlan, MD**
- **Dina Deldon-Saltin, DO**
- **Jaimee DeMone, MD**
- **Tiffany Forti, MD, MPH**
- **Cynthia Joslyn, CNM**
- **June O'Connor, MD**
- **Kerri Osterhaus-Houle, MD**
- **Stanley Surette, MD**
- **Leah Wilson, MD**

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# Prenatal Questionnaire

Patient's Name: _____ First day of last Menstrual period: _____/_____/_____

Physician's Name: _____

***The following questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. The following is a screening questionnaire only. For any further concerns, please contact your doctor.***

| | | |
|---|---|---|
| 1. Will you be age 35 or older when the baby is due? | Yes | No |
| 2. Have you or the baby's father had a previous child? | Yes | No |
| 3. Do you or the baby's father have a sibling with Down Syndrome | Yes | No |
| 4. Were you, the baby's father, any previous children, or any close relatives born with a neural tube defect (such as spinal bifida or anencephaly)? | Yes | No |
| 5. Does any male relative in your family have: | | |
| a. Hemophilia? | Yes | No |
| b. Muscular Dystrophy? | Yes | No |
| c. Hydrocephalus (water on the brain)? | Yes | No |
| 6. Do you or the baby's father have a birth defect, or have you had a child born dead or alive with a birth defect not listed in the above questions? | Yes | No |
| 7. Does any close relative on either side of the family have Cystic Fibrosis? | Yes | No |
| 8. Are there other known inherited or chromosomal disorders in the family? | Yes | No |
| 9. Do you have one or more close family members who are mentally retarded? | Yes | No |
| 10. Are you and the baby's father first cousins or more closely related? | Yes | No |

**-continued on reverse-**

11. Certain genetic diseases are more common in certain ethnic groups than others.

a. Are you of Black ancestry? Yes No

If yes, have you been tested for the Sickle Cell Trait? Yes No

If so, what were the results? _____

b. Are you of eastern European Jewish descent? Yes No

If yes, have you been tested to whether you are a Tay-Sachs carrier? Yes No

What were the results? _____

c. Are you of Asian or Mediterranean (Greek, Italian, ect.) descent? Yes No

If yes, have you been tested for Thalassemia trait? Yes No

What were the results? _____

12. Have you taken any medications or drugs (prescription or not) during this pregnancy? Yes No

If so, what kind? _____

13. Do you smoke and/or drink alcoholic beverages? Yes No

# Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

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As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

# Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

## SCORING

**QUESTIONS 1, 2, & 4 (without an *)**
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

**QUESTIONS 3, 5-10 (marked with an *)**
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)



## Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

**Name**_____

**DOB**___/___/_____ **Date** ___/___/_____

# PRENATAL PREECLAMPSIA QUESTIONNAIRE

## Assessment for High Risk of Preeclampsia

Have you ever been diagnosed with:

| | | |
|---|---|---|
| Pre-eclampsia? | NO | YES |
| Chronic hypertension (high blood pressure)? | NO | YES |
| Type 1 or 2 diabetes? | NO | YES |
| Renal (kidney) disease? | NO | YES |
| Auto-immune disease (examples: lupus, rheumatoid arthritis, Crohn's Disease) | NO | YES |

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**STAFF ONLY:**

If the patient has responded "yes" to 1 or more of the questions above OR if multiple fetuses (twins, triplets,…) are noted on ultrasound, please place the following statement in EMR Sticky Note section:

**"Screened POS low-dose aspirin."**

If all responses above are "no" AND this is a single-gestation pregnancy, please place the following statement in the EMR Sticky Note section:

**"Screened NEG low-dose aspirin."**

UMASS MEMORIAL MEDICAL CENTER

# MATERNITY PREADMISSION FORM

***Please Print Clearly***

Expected Due Date: _____ Obstetrician: _____ Primary Care Physician: _____

Patient Last Name: _____ First Name: _____

Date of Birth: _____ Maiden/Other Name: _____ Mother's First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: _____ Race: _____ Social Security Number: _____

Baby's Ethnicity: _____ Baby's Race: _____

Religion: _____ Place of Worship: _____

Interpreter Needed? ☐ Yes ☐ No Preferred Language: _____

## Employer Information

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Occupation (optional): _____

## Person to Notify in Case of an Emergency

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

## Insurance Information

Primary Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Policy Number as It Appears on Card: _____

Subscriber Name (if different from patient): _____ Relationship to Patient: _____

Effective Date (if noted on card): _____ Expiration Date (if noted on card): _____

Subscriber's Employer (if different than patient): _____

Group Number (if applicable): _____

Secondary Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

*Maternity Preadmission Form – Continued on page 28*

# MATERNITY PREADMISSION FORM – Continued

Telephone Number: _____ Policy Number as It Appears on Card: _____

Subscriber Name (if different from patient): _____ Relationship to Patient: _____

Effective Date (if noted on card): _____ Expiration Date (if noted on card): _____

Subscriber's Employer (if different than patient): _____

Group Number (if applicable): _____

## Baby Insurance (if different from mother)

Primary Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Policy Number as It Appears on Card: _____

Subscriber Name (if different from patient): _____ Relationship to Patient: _____

Effective Date (if noted on card): _____ Expiration Date (if noted on card): _____

Subscriber's Employer (if different than patient): _____

Group Number (if applicable): _____

Do you have a Health Care Proxy? ☐ Yes ☐ No

If yes, is it on file with the hospital? ☐ Yes ☐ No

If yes, who is the agent?

Name: _____ Phone: _____