

## 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

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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<sup>1</sup> (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      This would mean: "I have felt happy most of the time" during the past week.
- No, not very often      Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- |   |   |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me   |
| <input type="checkbox"/> As much as I always could            | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now                | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual    |
| <input type="checkbox"/> Definitely not so much now           | <input type="checkbox"/> No, most of the time I have coped quite well             |
| <input type="checkbox"/> Not at all                           | <input type="checkbox"/> No, I have been coping as well as ever                   |
| 2. I have looked forward with enjoyment to things             | *7. I have been so unhappy that I have had difficulty sleeping                    |
| <input type="checkbox"/> As much as I ever did                | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Rather less than I used to           | <input type="checkbox"/> Yes, sometimes   |
| <input type="checkbox"/> Definitely less than I used to       | <input type="checkbox"/> Not very often   |
| <input type="checkbox"/> Hardly at all                        | <input type="checkbox"/> No, not at all   |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable  |
| <input type="checkbox"/> Yes, most of the time                | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Yes, some of the time                | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Not very often                       | <input type="checkbox"/> Not very often   |
| <input type="checkbox"/> No, never                            | <input type="checkbox"/> No, not at all   |
| 4. I have been anxious or worried for no good reason          | *9. I have been so unhappy that I have been crying                                |
| <input type="checkbox"/> No, not at all                       | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Hardly ever                          | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Yes, sometimes                       | <input type="checkbox"/> Only occasionally  |
| <input type="checkbox"/> Yes, very often                      | <input type="checkbox"/> No, never  |
| *5. I have felt scared or panicky for no very good reason     | *10. The thought of harming myself has occurred to me                             |
| <input type="checkbox"/> Yes, quite a lot                     | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Yes, sometimes                       | <input type="checkbox"/> Sometimes  |
| <input type="checkbox"/> No, not much                         | <input type="checkbox"/> Hardly ever  |
| <input type="checkbox"/> No, not at all                       | <input type="checkbox"/> Never  |

Administered/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>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 .

<sup>2</sup>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

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# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Postpartum depression is the most common complication of childbearing.<sup>2</sup> 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](http://www.4women.gov)> and from groups such as Postpartum Support International <[www.chss.iup.edu/postpartum](http://www.chss.iup.edu/postpartum)> and Depression after Delivery <[www.depressionafterdelivery.com](http://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)

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## 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.

<sup>1</sup>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.

<sup>2</sup>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

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: \_\_\_\_\_