Chart ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Comprehensive Perinatal Services Program (CPSP)**

**Chart Review Tool**

CPSP Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Staff Present: (List all staff present and title) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Perinatal Services Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **ITEMS** | **Findings/Notes** |
| 1. Week started prenatal care
 |  |
| 1. Number of OB visits/follows ACOG recommended schedule
 |  |
| 1. Client Orientation is documented. (51348.d.1)
 |  |
| 1. Using approved assessment forms, initial, trimester and PP assessments completed.
 |  |
| 1. Nutrition Assessment
 |  |
| Diet evaluation used: 🞏24 hr. recall  food frequency questionnaire |  |
| Weight every visit; plotted on correct grid |  |
| Initial (within 4 weeks of initial visit) |  |
| Second Trimester |  |
| Third Trimester |  |
| Postpartum |  |
| 1. Psychosocial Assessment
 |  |
| Initial (within 4 weeks of initial visit) |  |
| Second Trimester |  |
| Third Trimester |  |
| Postpartum |  |
| 1. Health Education Assessment
 |  |
| Initial (within 4 weeks of initial visit) |  |
| Second Trimester |  |
| Third Trimester |  |
| Postpartum |  |
| 1. All documentation includes time in minutes
 |  |
| 1. All entries signed with name and CPSP title
 |  |
| 1. Appropriate use of STT or other materials
 |  |
| 1. An individual care plan is in place that:
2. Identifies client strengths
3. Addresses identified OB, health ed, psychosocial, nutrition needs.
 |  |
| 1. Care plan updated each trimester and postpartum
 | List dates |
| 1. Follow up on risks/issues identified in care plan
 |  |
| 1. Appropriate referrals documented including but not limited to:
 |  |
| 1. WIC
 |  |
| 1. Genetic Services
 |  |
| 1. CHDP/Well Child Pediatric Care
 |  |
| 1. Family Planning
 |  |
| 1. Dental
 |  |
| 1. Appropriate follow up of other referrals
 |  |
| 1. Who does case coordination?
 |  |
| 1. Dispensed or prescribed vitamin & mineral supplement
 |  |
| 1. Physician supervision documented per protocol
 |  |
| 1. Delivery record in chart (use to obtain birth outcome data, follow up if LBW, preterm, elective delivery before 39 wks, c-section)
 | Gender 🞏M 🞏FBirth weight \_\_\_\_lb. \_\_\_\_\_\_oz.Gestational age \_\_\_\_\_\_\_weeks Delivery method 🞏vaginal 🞏cesareanFeeding method: 🞏Breast🞏Formula 🞏 Combination |

**Corrective Action Plan: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**

|  |  |  |  |
| --- | --- | --- | --- |
| **Issue** | **Action Required** | **Person Responsible** | **Target Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |