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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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 🞏F  Birth weight \_\_\_\_lb. \_\_\_\_\_\_oz.  Gestational age \_\_\_\_\_\_\_weeks  Delivery method 🞏vaginal 🞏cesarean  Feeding method: 🞏Breast🞏Formula 🞏 Combination |

**Corrective Action Plan: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**

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