Congratulations on your pregnancy! NMCP is committed to providing you and your family with emotional and educational support as you move along your pregnancy journey. Packets are required to register for prenatal care. Please take your time and ensure that the forms are filled out completely and to the best of your knowledge. Once done, please submit the packet to the correct clinic. **Active duty members are assigned to the clinic closest to their duty station, while dependents are assigned to the clinic nearest their home address.** Any packets sent to the wrong location will need to be re-routed which may delay your care.

Once the packet is received, a registered nurse from the clinic will contact you within **FIVE** business days to review the information and schedule your first appointment. Try and submit packets when you are approximately **8 weeks pregnant** as your first appointment will not occur until 11 to 13 weeks gestation.

The OB clinics are **NOT** walk-in clinics. Concerns prior to your first appointment should be followed up with your PCM or the Emergency Room (if urgent). Staff are also unable to provide triage over the phone so please call the Nurse Advice Line for questions and concerns at 1-800-874-2273.

Packets can be submitted IN PERSON or by specific routes listed below:

Portsmouth Naval Hospital: (includes AD from the Naval Shipyard & NW Annex)
Fax: 757-953-4947
Email:usn.hampton-roads.navhospporsva.list.nmcp-womenshealthclinicteam@mail.mil

Dam Neck Base: (includes AD from Dam Neck and NAS Oceana)
Fax: 757-953-9887
Email: usn.hampton-roads.navhospporsva.list.nmcp-obdamneckclinicteam@mail.mil

Little Creek Base [Boone Clinic]: (includes AD at Little Creek NAB and Fort Story)
Email: usn.hampton-roads.navhospporsva.list.bhcboone-obgyn@mail.mil

Norfolk Base - Sewell's Point Clinic: (includes AD at Norfolk Base)
Fax: 757-953-9035

*Patients can also request a **FREE** copy of *Pregnancy and Childbirth: A Goal Oriented Guide to Prenatal Care*. Just ask for "the purple book" at any of our four OB clinics.

HEIGHT:
PRE-PREGNANCYWEIGHT:
BMI:

OBSTETRICAL PATIENT INTAKE

Date:	Full Name:	DOD ID #:	DOB:
Street Address:		City:	
State:	Zip:	Cell#: Home #: Email:	Work #:
Emergency Contact Name:		Emergency Contact #:	Marital Status:

First Day of your Last Menstrual Period:	**Allergies and Reaction:**	**Current Medications:**

Total Pregnancies:	# Deliveries 37 Weeks or Greater	# Deliveries Less than 37 Weeks	# Miscarriages	# Elective Abortions	# Ectopics	# Living Children

PRE-PREGNANCY WEIGHT_____ **HEIGHT**_____

****PLEASE LIST DETAILS TO "YES" ANSWERS ON THE BACK OF THIS PAGE AND LIST THE # ASSOCIATED WITH THAT ANSWER****

1. History of Diabetes / Gestational Diabetes?	( ) Yes ( ) No	26. Date of last Pap Smear?	
2. Hypertension? (High Blood Pressure)	( ) Yes ( ) No	27. History of Abnormal PAP? If so, what year?	( ) Yes ( ) No
3. Pre-eclampsia?	( ) Yes ( ) No	28. History of Sexually Transmitted Infection?	( ) Yes ( ) No
4. Autoimmune Disorder?	( ) Yes ( ) No	29. Do you or your partner have Genital Herpes?	( ) Yes ( ) No
5. Kidney Disease?	( ) Yes ( ) No	30. Uterine Anomalies?	( ) Yes ( ) No
6. Frequent Urinary Tract Infection?	( ) Yes ( ) No	31. Treatment for Infertility?	( ) Yes ( ) No
7. Neurologic Disorder / Epilepsy?	( ) Yes ( ) No	32. GYN Surgery?	( ) Yes ( ) No
8. Psychiatric History / Depression?	( ) Yes ( ) No	33. Recurrent pregnancy loss (>3) or stillbirth?	( ) Yes ( ) No
9. Hepatitis / Liver Disease?	( ) Yes ( ) No	34. Significant Family History (Cancer, Diabetes, etc)	( ) Yes ( ) No
10. Anemia that Required Medication?	( ) Yes ( ) No	35. Have you had the Chicken Pox? AGE?	( ) Yes ( ) No
11. Phlebitis / Varicose Veins?	( ) Yes ( ) No	36. Varicella Vaccine? AGE?	( ) Yes ( ) No
12. Thyroid Dysfunction?	( ) Yes ( ) No	37. Flu Vaccine? WHEN?	( ) Yes ( ) No
13. Pulmonary History (TB, Asthma, etc.)?	( ) Yes ( ) No	38. PPD? WHEN?	( ) Yes ( ) No
14. History of a Blood Transfusion?	( ) Yes ( ) No	39. Live with someone with TB or exposed to TB?	( ) Yes ( ) No
15. Negative Blood Type? (Rh)	( ) Yes ( ) No	40. High risk for Hepatitis?	( ) Yes ( ) No
16. Tobacco use prior to pregnancy?	( ) Yes ( ) No	41. Up To Date on Vaccinations?	( ) Yes ( ) No
17. Tobacco use since Last Menstrual Period?	( ) Yes ( ) No	42. History of Gastric Bypass Surgery?	( ) Yes ( ) No
18. Alcohol use prior to pregnancy?	( ) Yes ( ) No	43. Concerned about weight gain in pregnancy?	( ) Yes ( ) No
19. Alcohol use since Last Menstrual Period?	( ) Yes ( ) No	44. Nutrition Consult Requested?	( ) Yes ( ) No
20. Street Drug use prior to pregnancy?	( ) Yes ( ) No	45. Surgery/Hospitalizations other than childbirth?	( ) Yes ( ) No
21. Street Drug use since Last Menstrual Period?	( ) Yes ( ) No	46. Complications with Anesthesia?	( ) Yes ( ) No
22. Breast Concerns?	( ) Yes ( ) No	47. Any other chronic medical conditions?	( ) Yes ( ) No

OBSTETRICS PATIENT INTAKE FORM CONTINUED

1A. Will you be 35 or greater at time of delivery? ( ) Yes ( ) No			
For Questions 2- 15, have you or a family member been diagnosed with:			
2A. Thalassemia?	( ) Yes ( ) No	9A. Down Syndrome?	( ) Yes ( ) No
3A. Tay-Sachs Disease?	( ) Yes ( ) No	10A. Hemophilia? (Bleeding Disorder)	( ) Yes ( ) No
4A. Sickle Cell Disease or Trait? (Circle Which)	( ) Yes ( ) No	12A. Cystic Fibrosis?	( ) Yes ( ) No
5A. Neural Tube Defects? (Spina Bifida, Anencephaly)	( ) Yes ( ) No	13A. Huntington Chorea?	( ) Yes ( ) No
6A. Congenital Heart Defect?	( ) Yes ( ) No	14A. Mental Retardation	( ) Yes ( ) No
7A Muscular Dystrophy?	( ) Yes ( ) No	15A. Autism?	( ) Yes ( ) No
8A. Inherited Genetic or Chromosomal Disorders?	( ) Yes ( ) No	16A. Do you or the Father of the Baby have a child with birth defects?	( ) Yes ( ) No
****Circle ALL That Apply**** **Are you of African, Mediterranean, Haitian, Greek, Asian, Jewish, Cajun, or French Canadian descent? ( )Yes ( )No			

****IF YOU DESIRE CYSTIC FIBROSIS SCREENING, PLEASE ANSWER THE FOLLOWING QUESTIONS****

1B. What is the ethnicity of your mother?	3B. Is there a history of CF in your family?	( ) Yes ( ) No
2B. What is the ethnicity of your father?	4B. Do you have CF? If yes, do you have symptoms?	( ) Yes ( ) No

1C. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	( ) Yes ( ) No
2C. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	( ) Yes ( ) No
3C. Within the last year, has anyone forced or threatened you to have sexual activities with them?	( ) Yes ( ) No

****PAST PREGNANCIES/DELIVERIES:**

Date: Month/Year	Weeks	Length of Labor	Birth Weight	Male or Female	C-Section or Vaginal Delivery	Anesthesia	Place of Delivery	Preterm Yes/No	Complications: Bleeding, Vacuum/Forceps Delivery, Shoulder Dystocia, etc.

****USE THE REST OF THIS PAGE TO EXPLAIN ANY "YES" ANSWERS.**

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Phone: _____

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

MEDICAL RECORD - SUPPLEMENTAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE

GENETIC CARRIER SCREENING

Genetic carrier screening is a test that looks at your genes to determine whether you are a carrier of certain genetic disorders. A positive result tells you with greater than 99% certainty that you are a carrier of a specific genetic disorder, and you could be at risk of having an affected child. If a risk is identified, you may wish to consider genetic carrier screening for your partner, consult with your health-care provider, or pursue genetic counseling. If you are pregnant, prenatal testing can be performed to find out whether your baby has inherited the genetic disorder. We currently offer carrier screening for the following disorders:

Cystic fibrosis (CF) is a genetic disorder and leads to life-long illness. It causes the body to produce very thick mucus that can damage internal organs. It can lead to chronic lung infections, digestive problems, poor growth and infertility. Symptoms range from mild to severe, but do not affect intelligence. On average, CF patients live into their mid to late thirties. About 1 in every 3,500 babies born in the U.S. has cystic fibrosis. Screening of newborns for cystic fibrosis is now performed in every state.

Spinal muscular atrophy (SMA) is a genetic disorder that affects the control of muscle movement. It affects a person's ability to control their muscles, including those involved in breathing, eating, crawling and walking. SMA has different levels of severity, none of which affect intelligence. However, the most common form of the disorder causes death by age two. About 1 in every 6,000 to 1 in every 10,000 babies born in the US has SMA.

No test can detect 100% of genetic carriers. Even if your test results are negative, it is still possible that you could be a carrier of the genetic disorder, but the chance is small.

For the most accurate interpretation of test results, the laboratory needs correct information about your ethnic background, family history of genetic disorders and family relationships (especially paternity).

The decision to accept or decline genetic carrier screening is completely yours.

Your test results are confidential and will become a part of your medical record. Your test results will be sent only to the health-care provider who ordered the test, or his/her agent, unless otherwise authorized by you or required by law. Your health-care provider is responsible for interpreting the test results and explaining them to you. No other test will be performed and reported on your sample unless authorized by your health-care provider.

Before signing this form, I have had the opportunity to discuss genetic carrier screening with my health-care provider or someone he/she has designated. I understand that genetic counseling will be recommended if both I and my partner are carriers. My questions have been answered and I have all the information I need to make a decision at this time.

☐ **I want** carrier screening for CF

☐ **I do not want** carrier screening for CF

☐ **I want** carrier screening for SMA

☐ **I do not want** carrier screening for SMA

Patient Name (please print)

Patient Signature

Witness Signature

Date

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION:*(For typed or written entries, give: Name - Last, first, middle: SSN: Sex: Date of Birth: Rank/Grade.)*

HOSPITAL OR MEDICAL FACILITY	STATUS

DEPARTMENT / SERVICE	RECORDS MAINTAINED AT:

SPONSOR'S NAME	SSN

RELATIONSHIP TO SPONSOR

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
Women's Health Departmental SOP	16 Mar 2011

LOCAL FORM TITLE *(Optional)*
OB/GYN Clinic No Show Policy Statement

NO SHOW POLICY
OB/GYN CLINIC
Naval Medical Center Portsmouth

We are committed to offering you and your family the best medical care available and delivering this care in a timely fashion. In an effort to accomplish this mission, we need your help. So, we ask that you carefully read the following policy and understand that we are committed to meeting your healthcare needs.

1. **Active Duty:**
   a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
   b. I understand if I miss a scheduled appointment that my chain of command may be notified and this may result in being charged with an unauthorized absence.
   c. I understand if I am not able to keep my appointment, I will be held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.

2. **Family Members:**
   a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
   b. I understand that if I am not able to keep my appointment, I am held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.
   c. Failure to call the OB clinic prior to my appointment will result in a "NO SHOW".

Clinic "NO SHOWS" result in setbacks to your treatment plan and prevents other patients from being scheduled in your place.

Patient's Signature: _____ Date: _____

Sponsor's Signature: _____ Date: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

Category _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
ATTN TEAM NURSE FOR: Green Team____ Gold Team ____ Violet Team____ Blue Team____	620 JOHN PAUL JONES CIRCLE, BLDG 2 4TH FLOOR 4C&D PORTSMOUTH, VA 23708
c. TELEPHONE *(Include Area Code)* (757) 953-4300	d. FAX *(Include Area Code)* (757) 953-4947

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE	☐ CONTINUED MEDICAL CARE	☐ SCHOOL	☐ OTHER *(Specify)*
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION	
	☐ DATE *(YYYYMMDD)*	☒ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

NPSHVP Family Support Survey (FSS)

Baby's Mother's Name: _____ Baby's Due Date/DOB: _____

Circle Branch of Service: Army Air Force Navy Marine Corps Coast Guard

Mother's Date of Birth: _____ Baby's Father's Name: _____

Address: _____ Baby's Father's Date of Birth: _____

City, State: _____ Sponsor's SSN: _____ Rank: _____

Home phone #: _____ cell #: _____ Sponsor's Command: _____

Number of Children: _____ Ages: _____

How long have you lived in the area? _____ Email address: _____

Thank you for your cooperation in answering these questions. This information is to be used by the team of health care professionals providing care to you and your family. Federal laws governing the privacy of medical records also govern the collection, maintenance, use, retention and disposal of this information.

What is your military status?	Active Duty	Dual Military	Family Member Spouse	Family Member Daughter	Other
What is your marital status?	Single	Married	Divorced	Separated	Widowed
Is your spouse on deployment?	YES	NO	Length of deployment:		

STRONGLY DISAGREE: You feel strongly against the statement or strongly feel the statement is not true.
DISAGREE: You feel you cannot support the statement or you feel the statement is not true.
AGREE: You support the statement or feel this statement is true some of the time.
STRONGLY AGREE: You strongly support the statement or feel the statement is true most or all of the time.

	Instructions: Please place an "X" in the appropriate box for each question.	Strongly Disagree	Disagree	Agree	Strongly Agree	Score
1	My partner is very supportive of this pregnancy.					
2	I wish my partner and I got along better.					
3	I have thought seriously about ending my relationship with my partner.					
4	This is a very stressful time for me.					
5	At times I feel out of control, like I'm losing it.					
6	Uncontrolled anger can be a problem in my family.					
7	When I do drink, I drink enough to feel really high or drunk.					

	Instructions: Please place an "X" in the appropriate box for each question.	Strongly Disagree	Disagree	Agree	Strongly Agree	Score
8	I sometimes drink five or more alcoholic drinks at a time.					
9	My partner sometimes drinks five or more alcoholic drinks at a time.					
10	I can think of a situation when I would approve of a wife slapping a husband's face.					
11	When I was a teenager, I was hit a lot by my mother or father.					
12	When I was growing up, I saw my mother or father hit or throw things at their partner.					
13	My parents helped when I had problems.					
14	My income is often inadequate for basic needs (rent, food, clothing, transportation, etc.)					
15	I frequently feel as if I am not as good as others.					
16	I feel I do not have much to be proud of.					
17	All in all, I am inclined to think that I am a failure.					
18	Someone I am close to makes me feel confident in myself.					
19	I have someone to take care of my child/children for several hours if needed.					
20	I have someone I can count on in times of need.					
21	I think good things will happen to me in the future.					
22	There are times when I feel life is not worth living.					
23	I feel sad quite often.					
24	Have you or your partner been involved in a suspected or verified case of child abuse or neglect?					
25	Have you or your partner been involved in a suspected or verified case of spouse abuse?					
					Total Score	

This confidential information will not be disclosed to others without your informed written consent except to prevent serious, foreseeable and imminent harm to yourself or another person. It must be understood that social workers and health care professionals are mandated by state laws and Department of Defense regulations to report suspected or known spouse abuse, and child abuse and neglect.

Signature_____Date _____