

# CPSP Assessment Components - SAMPLE

Client Orientation

**CPSP Integrated Initial 1 and 2 & 3 Trimester Assessments and Individualized Care Plan**

**Client Orientation:**  
 Client orientation per protocol  States understands **Welcome to Pregnancy Care**  States understands CPSP is voluntary and agrees to participate  Reviewed STT HE, **Pregnant? Steps for a Healthy Baby**  Vitamins per protocol  
 Minutes: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date of Orientation: \_\_\_\_\_  
 Document additional Orientation in Progress Note

**Pregnancy Information:**  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 EDD: \_\_\_\_\_ Weeks Gestation \_\_\_\_\_

Client Identifier  
 Grav: \_\_\_\_\_ Para: \_\_\_\_\_ TAB: \_\_\_\_\_ SAB: \_\_\_\_\_

**OB problem list reviewed, if available, before conducting assessments.**  
 1<sup>st</sup> TM  2<sup>nd</sup> TM  3<sup>rd</sup> TM

Demographics

## Assessment / ICP Components - Psychosocial

Assessment

Individual Care Plan

**Psychosocial:**

Psychosocial Needs/Risks/Concerns (ask questions in Initial, 2 <sup>nd</sup> or 3 <sup>rd</sup> trimester as indicated)	Psychosocial Individualized Care Plan Developed with Client	Comment
1. Is this a planned pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No, describe: <input type="checkbox"/>	<input type="checkbox"/> Client states she understands STT PSY, <input type="checkbox"/> Uncertain about <b>Pregnancy, Choices</b> <input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Informed of CA Safe Surrender Law <input type="checkbox"/> Consult with OB provider <input type="checkbox"/> Referred to/for:	
2. Is this a wanted pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No, describe:		
3. Are you considering abortion/adoption? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:		
4. How does the FOB/Partner feel about the pregnancy? <input type="checkbox"/> Happy <input type="checkbox"/> Involved <input type="checkbox"/> Upset <input type="checkbox"/> FOB/Partner not sure <input type="checkbox"/> Uninvolved <input type="checkbox"/> FOB/Partner doesn't know <input type="checkbox"/> Client doesn't know how partner feels <input type="checkbox"/> Client wishes more support, identified sources:		
27. Discussed results of assessment with client and client identified the following strengths: <input type="checkbox"/>		

**Psychosocial**

<input type="checkbox"/> Minutes spent _____ Completed by: _____	Signature _____	Title _____	Date _____
<b>Signature of medical provider if assessor is CPHW:</b>			
<input type="checkbox"/> Minutes spent _____ Completed by: _____	Signature _____	Title _____	Date _____
<input type="checkbox"/> Minutes spent _____ Completed by: _____	Signature _____	Title _____	Date _____

Strengths

Minutes and Sign