## Manual Certification Form for PG

**CPA Signature:**_____ **Date:**_____

**Present for Cert** ☐ **Last Menstrual Period(LMP):**_____ **Expected Delivery Date:**_____

**Reason Not Present:** ☐ Medical Equipment Not Transportable ☐ Confined to Bed ☐ Serious Illness ☐ Transfer Out of State

### Breastfeeding Information

**How are you thinking about feeding your baby?**_____

**Have you ever breastfed/pumped?** ☐ No ☐ Yes **What have you heard about BF?**_____

**BF Referral to:**
- ☐ WIC
- ☐ Community Support
- ☐ No Referral Made

**Reason Referred:**
- ☐ Nipple Issues
- ☐ Needs Support/Unsure
- ☐ Breast Surgery
- ☐ Medical Condition
- ☐ 1st Time Pregnant
- ☐ General Support
- ☐ Expecting Multiples

**Reason Not Referred:**
- ☐ Baby Being Placed for Adoption
- ☐ CPA Professional Judgement
- ☐ Client Declined
- ☐ No Local Referral Resource Available

### Lab Data

**# of Prenatal Care Visits: _____ Date of First Visit - Month/Yr:_____ Pre-Preg Wt:_____lbs**

**Current Ht:_____in ____ 1/8 Current Wt:_____lbs _____oz _____ HGB _____**

**No Blood** ☐ **Exemption Reason:** ☐ CPA Determined Blood work skip ☐ Delayed Blood Work ☐ Medical Condition Prevents Safe Collection ☐ Religious Belief

### Pregnancy Information

**Currently Smoking?** ☐ No ☐ Yes **#/day?____** **3 months prior to pregnancy?** ☐ No ☐ Yes **#/day?_____**

**Smoking Change:** ☐ Decreased smoking ☐ Did not stop smoking ☐ Increased ☐ Not Applicable, did not smoke ☐ Started Smoking ☐ Stopped Smoking ☐ Tried to stop or decrease, but failed ☐ Unknown or refused to answer

**Does anyone smoke inside the home?** ☐ No ☐ Yes

**Current alcohol intake?** ☐ No ☐ Yes **#/week?_____** **3 months prior to preg?_____** ☐ No ☐ Yes **#/week?____**

**Are you consuming recreational drugs?** ☐ No ☐ Yes _____

**Is this your 1st pregnancy?** ☐ Yes ☐ No **Date last pregnancy ended?_____(mm/yyyy)**

**Pregnancies: # of previous? _____ # lasting ≥ 20 wks?_____ # resulting in live birth?_____**

**During any previous pregnancy did you have:** ☐ Gestational DM ☐ Preeclampsia ☐ Premature delivery (37 weeks or less)

☐ Infant weighing 5lb 8oz or less ☐ Infant weighing 9lbs or more ☐ 2 or more spontaneous abortions or any fetal death

☐ Infant w/ congenital or other birth defect

### Health Information

**# of infants you are BF?** ☐ 0 ☐ 1 ☐ 2+ **# of infants you are MBF?** ☐ 0 ☐ 1 ☐ 2+ **# of infants you are EBF?** ☐ 0 ☐ 1 ☐ 2+

**What concerns, if any, about your weight?**_____

Do you take any medicine? ☐ Yes ☐ No What kind?_____

**In the month prior to becoming pregnant, did you take any vitamins, minerals?** ☐ No ☐ Yes **#/week?_____**

**Currently, do you take any vitamins/minerals?** ☐ No ☐ Yes **What kind?_____ #/week?_____**

**Excessive?** ☐ No ☐ Yes

**Currently do you take any herbal products?** ☐ No ☐ Yes **What kind?**_____

Have you been experiencing: ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting/upset stomach ☐ Difficulty chewing or swallowing

Do you go for regular dental check ups? ☐ No ☐ Yes

### Nutrition Information

**How do you feel about your appetite?**_____

Are you on any special diet?_____

Tell me about your daily physical activity:_____

**Do you consume any non food items?** ☐ No ☐ Yes **What items?**_____

**Do you consume any cold deli meats, cold hot dogs, raw or undercooked meats or eggs, soft cheese, raw fish, raw sprouts, or unpasteurized foods?** ☐ No ☐ Yes **What foods?**_____

## Nutrition Risk (* = High Risk)

### Medical Conditions

- ☐ *301 Hyperemesis Gravidarum
- ☐ *302 Gest. Diabetes
- ☐ 303 Hx of Gest. Diabetes
- ☐ 304 Hx of Preeclampsia
- ☐ 311 Hx of Preterm
- ☐ 312 Hx of Low Birth Wt.
- ☐ 321 Hx of Spon. Abortion, Fetal or Neonatal Loss
- ☐ *331 Pregnancy at a Young Age
- ☐ 332 Closely Spaced Pregnancies
- ☐ 333 High Parity and Young Age
- ☐ 335 Multifetal Gestation
- ☐ 336 Fetal Growth Restriction
- ☐ 337 Hx of Birth w/ Lg for Gestational Age Infant
- ☐ 338 PG Woman Currently BF
- ☐ 339 Hx of Birth w/ Nutrition Related Congenital or Birth Defect
- ☐ 341 Nutrient Deficiency Diseases
- ☐ 342 Gastro-Intestinal Disorders
- ☐ *343 Diabetes Mellitus
- ☐ 344 Thyroid Disorders
- ☐ 345 HTN or PreHTN
- ☐ 346 Renal Disease
- ☐ *347 Cancer
- ☐ 348 Central Nervous System Disorders
- ☐ 349 Genetic and Congenital Disorders
- ☐ 351 Inborn Errors of Metabolism
- ☐ 352 Infectious Diseases
- ☐ 353 Food Allergies
- ☐ 354 Celiac Disease
- ☐ 355 Lactose Intolerance
- ☐ 356 Hypoglycemia
- ☐ 357 Drug Nutrient Interactions
- ☐ 358 Eating Disorders
- ☐ 359 Recent Major Surgery, Trauma, Burns
- ☐ 360 Other Medical Conditions
- ☐ 361 Depression
- ☐ 362 Dvlpmntl, Sens.or Motor Delays
- ☐ 371 Maternal Smoking
- ☐ 372 Alc. & Illegal Drug Use
- ☐ 381 Oral Health Conditions

### Nutrition and Other Risk Factors

- ☐ 401 Failure to Meet Dietary Guidelines
- ☐ 427.01 Consuming Suppl. w/ Potentially Harmful Consequences
- ☐ 427.02 Diet Very Low Calories/Nutrients; Impaired Intake/Absorption
- ☐ * 427.03 Compulsively Ingesting Non-Food Items(PICA)
- ☐ 427.04 Inadequate Essential Vit/Min
- ☐ 427.05 PG ingesting foods that could be contamined
- ☐ 901 Recipient of Abuse
- ☐ *902 Woman or Infan/Child of Primary Caregiver w/ Limited Ability to Make Feeding Decisions and/or Prepare Food
- ☐ 904 Env. Tob. Smoke Exposure

## Nutrition Education

**Method:** ☐ Ind - Cert ☐ HH - Cert ☐ Ind - F/U ☐ HH - F/U ☐ Internet - F/U ☐ Group - F/U

### Topic

### Referrals

### Food Package

- ☐ Milk or Lacto-free / Soy / Evap / Pwdr / UHT
- ☐ Cheese ☐ Eggs ☐ PN Butter ☐ Juice ☐ Cereal
- ☐ Yogurt ☐ Fish ☐ Beans ☐ CVB ☐ Whole Grains

### Type of Formula/Medical Food:

### Amount per day:

## Notes

☐ NE Counseling Note ☐ Ind Care Plan/Follow Up ☐ BF Note

### General Note:

**Benefit Issuance:** ☐ Monthly ☐ Bi-Monthly ☐ Tri-Monthly

**Schedule Appointment:**