

Comprehensive Perinatal Services Program (CPSP) Multi-Chart Review Tool

CPSP Provider: _____ Date: _____ Perinatal Services Coordinator: _____

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

ITEMS	Findings				
	1	2	3	4	5
1. Week started prenatal care					
2. Number of OB visits/follows ACOG recommended schedule					
3. Client Orientation is documented					
4. Using approved assessment forms, initial, trimester and PP assessments completed					
a. Nutrition Assessment					
Diet evaluation used: <input type="checkbox"/> 24 hr. recall <input type="checkbox"/> food frequency questionnaire					
<input type="checkbox"/> Weight every visit; <input type="checkbox"/> plotted on correct grid					
<input type="checkbox"/> Initial (within 4 weeks of initial visit)					
<input type="checkbox"/> Second Trimester					
<input type="checkbox"/> Third Trimester					
<input type="checkbox"/> Postpartum					
b. Psychosocial Assessment					
<input type="checkbox"/> Initial (within 4 weeks of initial visit)					
<input type="checkbox"/> Second Trimester					
<input type="checkbox"/> Third Trimester					
<input type="checkbox"/> Postpartum					
c. Health Education Assessment					
<input type="checkbox"/> Initial (within 4 weeks of initial visit)					
<input type="checkbox"/> Second Trimester					
<input type="checkbox"/> Third Trimester					
<input type="checkbox"/> Postpartum					
5. All documentation includes time in minutes					
6. All entries signed with name and CPSP title					
7. Appropriate use of STT or other materials					
8. An individual care plan is in place that:					
a. Identifies client strengths					
b. Addresses identified OB, health ed, psychosocial, nutrition needs.					
c. Care plan updated each trimester and postpartum (dates)					

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9. Follow up on risks/issues identified in care plan					
10. Appropriate referrals documented including but not limited to:					
a. WIC					
b. Genetic Services					
c. CHDP/Well Child Pediatric Care					
d. Family Planning					
e. Dental					
11. Appropriate follow up of other referrals					
12. Who does case coordination?					
13. Dispensed or prescribed vitamin & mineral supplement					
14. Physician supervision documented per protocol					
15. Delivery record in chart (use to obtain birth outcome data, follow up if LBW, preterm, elective delivery before 39 wks, c-section)	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth weight ____lb. ____oz. Gestational age ____weeks Delivery method: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Combination	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth weight ____lb. ____oz. Gestational age ____weeks Delivery method: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Combination	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth weight ____lb. ____oz. Gestational age ____weeks Delivery method: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Combination	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth weight ____lb. ____oz. Gestational age ____weeks Delivery method: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Combination	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth weight ____lb. ____oz. Gestational age ____weeks Delivery method: <input type="checkbox"/> vaginal <input type="checkbox"/> cesarean Feeding method: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Combination

Corrective Action Plan:

Issue	Action Required	Person Responsible	Target Date