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: ☐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					
b. Psychosocial Assessment					
☐Initial (within 4 weeks of initial visit)					
☐Second Trimester					
☐Third Trimester					
☐Postpartum					
c. Health Education Assessment					
☐Initial (within 4 weeks of initial visit)					
☐Second Trimester					
☐Third Trimester					
☐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)					

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

ITEMS	Findings				
	1	2	3	4	5
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 ☐M ☐F Birth weight ____lb. ______oz. Gestational age _______weeks Delivery method: ☐vaginal ☐cesarean Feeding method: ☐Breast ☐Formula ☐ Combination	Gender ☐M ☐F Birth weight ____lb. ______oz. Gestational age _______weeks Delivery method: ☐vaginal ☐cesarean Feeding method: ☐Breast ☐Formula ☐ Combination	Gender ☐M ☐F Birth weight ____lb. ______oz. Gestational age _______weeks Delivery method: ☐vaginal ☐cesarean Feeding method: ☐Breast ☐Formula ☐ Combination	Gender ☐M ☐F Birth weight ____lb. ______oz. Gestational age _______weeks Delivery method: ☐vaginal ☐cesarean Feeding method: ☐Breast ☐Formula ☐ Combination	Gender ☐M ☐F Birth weight ____lb. ______oz. Gestational age _______weeks Delivery method: ☐vaginal ☐cesarean Feeding method: ☐Breast ☐Formula ☐ Combination

Corrective Action Plan:

Issue	Action Required	Person Responsible	Target Date