

PREGNANCY DETERMINATION

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

SUBJECTIVE: Chief Complaint / Why are you here today? _____

No Yes

- Have you done a home pregnancy test? If yes, what was the result? _____
- If you are pregnant, what do you want to do? Abortion Adoption Parenting Undecided
- First day of your Last Normal Period: _____
- This period was: on time early late
- The amount of bleeding was: normal lighter heavier
- Are your cycles: regular irregular miss periods?
- Period come every _____ days.
- *Any bleeding or spotting since your last period?
- * Any lower abdominal pain or discomfort, shoulder or leg pain?
- When was your last act of intercourse? _____
- Did you use a method of birth control? Type: _____
- Are you having symptoms of pregnancy?
- Have you ever been pregnant?
- Age at first pregnancy _____ # of pregnancies _____ Date at end of last pregnancy _____
- Please indicate number and outcome of all previous pregnancies:
- Full Term Still Birth Abortion Miscarriage Tubal Pregnancy
- Have you ever had (check all that apply): Chlamydia *Infection after an abortion or delivery
- Gonorrhea *Infection of uterus or tubes (PID)
- Do you have any medical problems?
- Have you taken any medications in the last 48 hours?
- Have you ever been forced to have sex?
- Afraid of your partner(s) / others?
- Parent(s) or guardian is aware of your visit today? (Only answer if under age 18.)

Patient Signature: _____ Date: _____

FOR STAFF USE ONLY

OBJECTIVE:

Pregnancy Test Result: Negative Positive Weeks since LNMP: _____

Laboratory:

No Yes	Pos	Neg
<input type="checkbox"/> <input type="checkbox"/> Chlamydia – Cervix /Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> GC – Cervix /Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> HIV	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> RPR	<input type="checkbox"/>	<input type="checkbox"/>

ASSESSMENT / PLAN: Negative Pregnancy Test

No Yes

- Advised to return to center for repeat pregnancy test in 2-4 weeks if no menses
- Encouraged to return to center for complete GYN exam
- HIV risk assessment performed / screening offered
- Safer sex information offered
- Birth Control information offered
- Advised to see other medical provider
- Pt. encouraged to discuss visit with parent or guardian

Staff Signature & Title _____

Plan of Care Approval:

No Yes

- UPT/STI Screening PRN
- ECP (LoOvral 8/Levlen 8) x 1 year
- Rx Issued: _____
- Other _____

Clinician Signature: _____

Fact Sheets given:

- AIDS & HIV Antibody Test (N200)
- Emergency Contraception Pills (N51)
- Birth control CIIC, List #: _____
- Preconception Care (N75)
- Other: _____

Date: _____

FOR STAFF USE ONLY

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

ASSESSMENT / PLAN: Positive Pregnancy Test

Patient plans: Abortion Adoption Parenting Undecided

Assessment of Decision-Making and Emotional Support

What do you feel about the pregnancy?

Notes: _____

Can you tell me about the support you have from your partner, family, or friends?

Notes: _____

ASSESSMENT / PLAN:

No Yes

- Client centered pregnancy options counseling offered
- Client informed about what to expect emotionally and physically before, during and after abortion, including that a range of emotions is normal.
- HIV risk assessment performed / screening offered
- Safer sex information offered
- Pt. encouraged to discuss visit with parent or guardian
- Patient advised to have pelvic sizing exam

Information/Facts sheets given:

- Ectopic precautions (N14)
- Having a Healthy Baby – Prenatal Care (N76)
- Adoption (N15)
- AIDS & HIV Antibody Test (N200)
- Pre-Abortion Instructions (N1000)
- About Your Abortion (N1027)
- Medical AB Q&A (N1047)
- Foster Care
- Other: _____

Referral form (NXXX) given for:

- Abortion counseling support (Backline, Exhale, Image)
- Abuse/Partner Violence
- Adoption
- Mental Health/Counseling
- Prenatal Care
- Sexual Assault/Rape
- 1st Trimester Referrals (N1005)
- 2nd Trimester Referrals (N1006)
- Other: _____

Staff Signature & Title _____

Date: _____