



CRISP

OB Patient Form Portlet Training Guide

December 5th, 2017

7160 Columbia Gateway Drive, Suite. 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org




Section 1. Overview


Topics:

1. Homepage and Login
2. Patient Information and Background
3. Risk Factors and Medical History
4. Referrals
5. Medication & Late Entry
6. Generating Patient Reports
7. Conclusion




Section 1.1 Form Portlet Homepage

 Home Screen lets you start logging a new patient's information

 All new forms start with basic health insurance information
(As well as name, last name, etc)

Easy-to-use text boxes 

OB Welcome [OB Assessment](#) [Sign In](#) 

OBPatientForm Portlet

Please complete the form below. Required fields are marked with asterisks.

*** Health Plan**
Select a Health Plan

Provider Information


*** Provider Name** *** NPI / Provider Number** *** Phone** *** Fax**


Patient Information

*** First Name** **MI** *** Last Name**



Section 1.2 Inputting Patient Information

 The form continues with basic information about the patient

Health insurance member ID 

Basic contact information 

Input medical information 

Expected delivery center 

Patient Information

* First Name MI * Last Name

* Member ID / MA Recipient Number

* Date of Birth * Age
mm/dd/yyyy

* Home Phone * Alternate Phone

* Date of First Prenatal Visit * Date of EDC
mm/dd/yyyy mm/dd/yyyy

* Language

* BMI * Gravida * Para * TAB * Live Births * Gestational Age (weeks)

* Hospital/Birthing Center for Delivery
 HUH Providence UMC WHC GWUH Other



Section 1.3 Risk Factors & Medical History

+ Discuss past complications and risk factors

Past OB Complications / Current Risk Factors.

Check all that apply (P = Past pregnancy, C = Current pregnancy)

P	C	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17 - P Administration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Placenta
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia Hb < 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical cerclage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hypertension, pregestational
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clotting disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental visit > 6 mos ? Oral Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression / Mental Health
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, pregestational
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ectopic pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fetal loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gestational Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis

← For past and current pregnancies

1st 2nd 3rd ← By trimester inputs

Cardiac details

Clotting disorder details

Oral Problem details

Disability details

Eating Disorder details

1st 2nd 3rd

Hepatitis details

Other Health And Social Needs

Please answer all questions below

You, Your Family and Partner

Yes No

Do you have children in your home or under your care? _____
How many?

Yes No Is your partner involved with your pregnancy?

Yes No Is your husband or partner employed?

Yes No Are you employed?

Yes No

Do you feel that you have enough help from your family or friends to care for your new baby?

Yes No If you could change the timing of this baby would you want to?

Yes No

Did you consider adoption or abortion at any point during this pregnancy?

Yes No Are you currently in foster care?

Yes No Has CFSA been involved with any of your children?

Yes No

Are you currently working with a case manager, therapist, or counselor?

Yes No Have you seen a probation officer in the last 12 months?

Yes No

Do you worry about getting food when you need it or getting quality food?

Yes No Do you currently receive WIC benefits?

Yes No Do you currently receive food stamp/EBT?

← Home family life and background questions



Section 1.3 Risk Factors & Medical History Continued

Transportation, Housing and Environmental Exposures

Yes No

Have you moved in the last 3 months? How often?

Yes No

Are you homeless or worry that you could become homeless soon?

Yes No Have any of your children had a positive blood test for lead?

Yes No

Do you have pets? What kind?

Yes No Do you have cockroaches or rodents in your home?

Yes No Does anyone in your household smoke?

Yes No Are there any leaks or mold in your home?

Yes No

Do you have any problems getting to doctor visits or appointments?

Transportation
and Housing
Risk Factors

Domestic Violence (ACOG 3-Question Screen)

Yes No

Within the past year, or since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes No

Are you in a relationship with someone who threatens or physically hurts you?

Yes No

Have anyone forced you to have sexual activities that made you feel uncomfortable?

Domestic
Violence
Factors

4 Ps Plus

Yes No Did either of your parents have a problem with drugs or alcohol?

Yes No Does your partner have any problem with drugs or alcohol?

Yes No Have you ever felt manipulated by your partner?

Yes No Have you ever felt out of control or helpless?

Over the past 2 weeks

Yes No Have you ever felt down, depressed or hopeless?

Yes No Have you felt little interest or please in doing things?

In the month before you knew you were pregnant:

About how many cigarettes did you smoke per week?

None Less than half pack About 1 pack More than 1 pack

How many days per week did you drink beer/wine/liquor?

None Less than 1 1-2 3-6 Everyday

How many days per week did you use marijuana, cocaine, or heroin?

None Less than 1 1-2 3-6 Everyday

And now?:

About how many cigarettes do you smoke per week?

None Less than half pack About 1 pack More than 1 pack


How many days per week do you drink beer/wine/liquor?


None Less than 1 1-2 3-6 Everyday


Mental and
Physical
Factors covered



Section 1.4 Referrals

 The referrals section allows a doctor to input whether a referral has been completed, is needed, or is N/A

 Referrals cover domestic violence, substance abuse, Home environment factors, genetic factors, mental Health factors, and more.

 Medical practitioners can then keep track of needed Referrals and follow up on them


Referrals


C = referral completed; N = referral needed; N/A = Not Applicable

C	N	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	APRA/Substance Abuse Program
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Domestic Violence Services
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Risk OB/Maternal Fetal Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Home Environment Assessment
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Home Visiting Agency
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Genetics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	MCO Care Coordination/Case Management
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Non Obstetric Specialt Medical Care
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Nutritional Counselling/Nutritionist



Section 1.5 Medication & Late Entry

 Similar to referrals, practitioners can note medications the patient is taking

 The “Late Entry into Prenatal Care” Section allows practitioners to mark any factors that forced a patient not to seek out prenatal care until after the 1st trimester

Medication

Late Entry Into Prenatal Care

First prenatal visit after 1st trimester. Check all that apply

- Yes No Lack of health insurance
- Yes No Unaware of the importance of prenatal care
- Yes No Childcare issues
- Yes No Unable to find a health care provider
- Yes No Unsure of keeping pregnancy to term
- Yes No Financial problems
- Yes No Unable to find an appointment in the first trimester

Yes No

Other (specify) _____



Section 1.6 Patient Report

Health Plan

Amerihealth Caritas District of Columbia

Provider Information

Provider Name:	Absolute Providers LLC
NPI / Provider Number:	12345
Phone:	202-555-5555
Fax:	202-555-6666

Patient Information

First Name:	John
MI:	Q
Last Name:	Pulbic
Member ID / MA Recipient Number:	54321
Date of Birth:	12/12/1997
Age:	30
Home Phone:	202-555-1111
Alternate Phone:	202-555-1112
Date of First Prenatal Visit:	00/01/2017
Date of EDC:	00/02/2017

➔ Generate reports with provided information

➔ Print & view reports

➔ Export reports as a PDF



Section 1.7 Conclusion

OB

Welcome

OB Assessment

Search

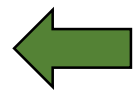
Sign In



OBPatientForm Portlet

Thank you for completing the form. The information was successfully submitted.

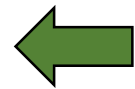
ENTER ANOTHER PATIENT



Able to immediately start a new patient

Print/Download PDF

EXIT



And export or print results of the form

Powered By Liferay