CPSP ORIENTATION CHECKLIST

Provider:		
Patient:	DOB: EDD: _	
Date Discussed	SUBJECT	
	□ Perinatal services to be provided (including CPSP) Name of Handout: *See Handout STT/HE-7	
	Who will provide services Name of Handout or N/A	
	☐ Where services will be provided Name of Handout or N/A	
	Danger signs of pregnancy-what to do if they occur Name of Handout: *See Handout STT/HE-9 Date of Handout: *See Handout STT/HE-9	
	□ Patient Rights and Responsibilities Name of Handout:* See Handout STT/HE-11 □ HIV information/courseling given & HIV testing offered	
	 □ HIV information/counseling given & HIV testing offered Name of Handout:* See Handout STT/HE-35 □ Substances to avoid during pregnancy 	
	Name of Handout or N/A Group Classes available	
	Name of Handout or N/A Fetal movement monitoring (24-28 wks.) Name of Handout:	
	☐ Integrated Prenatal Screening—(a)1st Trimester lab: 10 wks/0days-13 wks/6days. (b) 2nd Trimester lab: 15-wks/0 days- 20-wks/0 days.	
	Name of Handout: Genetic Risks/Testing	andout &Reviewed No
	Name of Handout or N/A Delivery Site Options	
	Name of Handout or N/A Financial Responsibility Name of Handout or N/A	
	□ Other Subject/s	

The information checked above has been reviewed with me and I have had the opportunity to ask questions. I understand that as an active participant in my perinatal care, it is my responsibility to ask questions when I have a concern or problem.

Date		Client Signature	Practitioner /CPHW Signature	Total Minutes
	Initial Client			
	Orientation			
	Follow-Up			
	Orientation			
	Follow-Up			
	Orientation			
	Follow-Up			
	Orientation			