EAST ORANGE CHILD DEVELOPMENT CORPORATION

HEALTH SERVICES HAND BOOK

PREGNANT WOMEN

&

EXPECTANT FAMILIES IN EARLY HEAD START

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CONTACT PERSON:

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HEALTH MANAGER

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CONTACT PERSON:

LATONYA GREEN

FAMILY WORKER

WELCOME TO OUR PREGNANCY PROGRAM:

AS AN ENROLLEE THE FOLLOWING WILL BE PROVIDED:

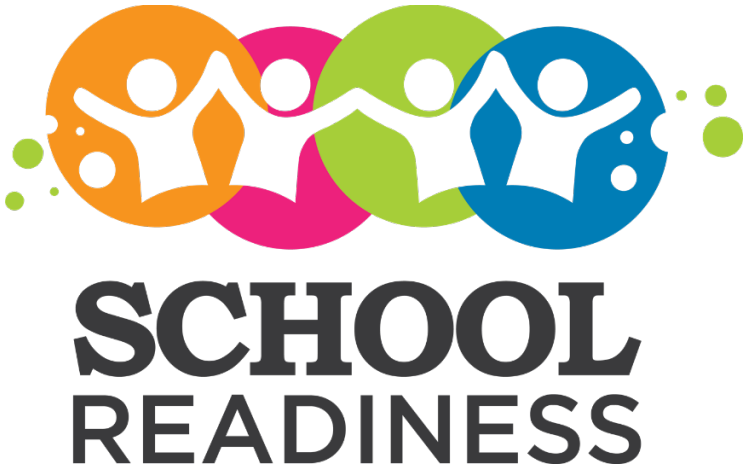
- PRENATAL AND POSTPARTUM EDUCATION/RESOURCES
- INDIVIDUALIZED PRENATAL/POSTNATAL SESSIONS
- NUTRITION ASSESSMENT AND COUNSELLING
- NEWBORN VISIT
- ASSISTANCE AND GUIDANCE WITH TRANSITION INTO CENTERBASE

Early Head Start
Learning Begins at Birth

IN THE PREGNANT WOMEN PROGRAM, THE PROCESS INCLUDES:

- HEALTH INTAKE- TO OBTAIN INFORMATION ON PRENATAL HISTORY, ACCESS TO ONGONG HEALTH CARE AND DEVELPOMENT OF INDIVIDUAL TRACKING OF HEALTH NEEDS.
- SOCIAL SERVICE-DETERMINATION OF ELIGIBILITY IN THE PROGRAM, INQUIRE THE NEEDS OF THE FAMILY AND OBTAINING FAMILY SUPPORT SYSTEM.
- PRENATAL SESSIONS THROUGHOUT THE PREGNANCY, AS WELL AS LABOR & DELIVERY AND POSTPARTUM EDUCATION PRIOR TO DELIVERY.

- TWO WEEK NEWBORN/POSTPARTUM VISIT, NEWBORN ASSESSMENT, LABOR AND DELIVERY HISTORY, POSTPARTUM SCREENING AND POSTNATAL RESOURCES AND REFERRALS.
- SCHOOL READINESS- ONGOING EDUCATION, GUIDANCE DURING PREGNANCY AND DELIVERY. ASSISTANCE AND GUIDANCE IN THE TRANSITION OF CHILD INTO THE CENTERBASE PROGRAM.



SCHOOL HEALTH READINESS

- PRENATAL VISITS-PHYSICAL CHECK-UP AND FORM SUBMISSION
- DENTAL EXAM-DENTAL CHECK UP AND FORM SUBMISSION
- NUTRITION COUNSELLING WITH E.O.C.D.C. NUTRITIONIST
- MONTHLY PREGNANT MOM SESSIONS WITH NURSE
- REGULAR CHECK-INS REGARDING PREGNANCY WITH HEALTH ASSISTANT
- NEWBORN/POSTPARTUM VISIT COMPLETION
- ASSISTANCE AND GUIDANCE FOR TRANSITION INTO CENTERBASE

PRENATAL PHYSICAL FORM

Dear Health Care Provider:

Please complete the following form. This will help us to follow-up on this client, who is enrolled in our program. Please stamp your agency's name in the space below.

1. Name of Health Care Provider:

Telephone#:

2. Name of Client _____

Date of Birth _____/_____/_____

3. Physical Examination Completed: Date_____/_____/_____

4. Examination Results:

5. Special Needs/Conditions

6. Pregnancy Trimester:

First: _____ B.P._____

Second _____

Third _____ Hg/Hct_____

Post-Partum: _____

7. Immunizations-Given _____

_____

_____

Signature of Health-Care Provider

NATIONAL CENTER ON
Early Childhood Health and Wellness

Head Start Oral Health Form—Pregnant Women

Patient Information

Patient's name _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the patient's dental home: Yes No

Current Oral Health Status

Does the patient have any teeth with untreated decay? Yes (decay) No (decay free)

Does the patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Does the patient have gum disease? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination:	Yes	No
X-rays:	Yes	No
Risk assessment:	Yes	No
Cleaning:	Yes	No
Fluoride varnish:	Yes	No
Dental sealants:	Yes	No

Counseling/Anticipatory Guidance

Yes No

Referral to Specialty Care

Yes No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings:	Yes	No
Crowns:	Yes	No
Extractions:	Yes	No
Emergency care:	Yes	No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ /_____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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