Prenatal Exam Form

STARFISH FAMILY SERVICES

_____ is enrolled in the Starfish Birth to Five or DEHS Early Head Start Home Visiting Program.

Following the exam, please complete this form and return to the patient.

Date of Visit: _____ **Due Date**: _____

Physical exam results:

BP _____/_____ Weight: _____ Hemoglobin:_____ Tdap _____ Rh _____

This exam was within normal limits ☐ Yes ☐ No, explain _____

Is this a high risk pregnancy? ☐ No ☐ Yes, explain _____

Anticipated Needs: (Please check those that apply and provide additional comments, as needed)

☐ Nutrition Follow-up _____

☐ Dental Follow-up _____

☐ Mental Health Intervention _____

☐ Prenatal Education _____

☐ Substance Abuse Intervention _____

☐ Breastfeeding _____

Please, list any <u>risks</u> or <u>concerns</u> that we can help with in serving this pregnant woman:

_____

_____

Referrals: _____

_____

_____

Date of next prenatal visit:_____/_____/_____

_____ _____

Health Care Provider (HCP) **Date** Address

_____ _____

Print Name (HCP) Phone

Head Start Use Only:

Date & initials received _____ Entered in Child Plus ☐ Attachment in ChildPlus ☐ 2026