


4 P's Plus

Perinatal Addictions
Prevention Project 

Screening and Referral Tool

Today's Date

month /	

day /	

year /	

Prenatal Provider

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Fill-in circles completely

Client SSN (last 4 digits) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Residence <input type="text"/> <input type="text"/> County Code (see back pg 1) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Zip Code	Screen Interval <input type="radio"/> Entry <input type="radio"/> 28 weeks <input type="radio"/> Postpartum <input type="radio"/> Other	Hispanic/Latino <input type="radio"/> Yes <input type="radio"/> No Preferred Language <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other (specify) _____	Race <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Asian <input type="radio"/> American Indian <input type="radio"/> Native Hawaiian/Alaskan Native <input type="radio"/> Other <input type="radio"/> Declines to answer <input type="radio"/> None of the above	Insurance <input type="radio"/> Private <input type="radio"/> Medicaid <input type="radio"/> Uninsured Age <input type="radio"/> <15 <input type="radio"/> 26-39 <input type="radio"/> 15-17 <input type="radio"/> >40 <input type="radio"/> 18-25
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4 P's Plus Screen		Provide substance abuse brochure	Refer for domestic violence assessment	Provide substance abuse brochure	Continue with follow-up questions
Parents	Did either of your parents have any problems with drugs or alcohol?	<input type="radio"/> Yes <input type="radio"/> No			
Partner	Does your partner have any problem with drugs or alcohol?	<input type="radio"/> No	<input type="radio"/> Yes		
	Is your partner's temper ever a problem for you?	<input type="radio"/> No	<input type="radio"/> Yes		
Past	Have you ever drunk beer/wine/liquor?	<input type="radio"/> No		<input type="radio"/> Yes	
Pregnancy	In the month before you knew you were pregnant, how many cigarettes did you smoke?	<input type="radio"/> None			<input type="radio"/> Any
	In the month before you knew you were pregnant, how much wine/beer/liquor did you drink?	<input type="radio"/> None			<input type="radio"/> Any
	In the month before you knew you were pregnant, how much marijuana did you use?	<input type="radio"/> None			<input type="radio"/> Any

Refused Screen

Follow-Up Questions not indicated

Follow-Up Questions	Refer for substance abuse assessment		Refer for prevention education services		No referral needed
	Every Day	3 to 6 days a week	1 or 2 days a week	Less than 1 day a week	Did not drink/do drugs
In the month before you knew you were pregnant about how many days a week did you usually:					
- drink beer, wine or liquor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
- use any drug such as marijuana, cocaine or heroin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
And now, about how many days a week do you usually:					
- drink beer, wine or liquor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
- use any drug such as marijuana, or cocaine or heroin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Referrals complete for all patients	Referred		
	Yes	No	Refused
Substance Abuse Assessment <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Tx Provider Code (see back pages)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking Cessation Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prevention Education Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments:

Send **White** copy to your MCH Consortium Keep **yellow** copy