OBSTETRIC PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STATUS_____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER _____ OCCUPATION _____

RACE:

○ White	○ Asian	○ Other
○ Black/African American	○ Hispanic or Latino (no race info available)	○ Decline to Answer
○ American Indian or Alaskan Native	○ Native Hawaiian or Pacific Islander	

ETHNICITY:

○ No, not Spanish/Hispanic/Latino	○ Decline to Answer	○ Unknown
○ Yes/Cuban ○ Yes/Puerto Rican	○ Yes, Mexican, American, Chicano	○ Yes, Other Hispanic ○ (Specify)_____

PREFERRED LANGUAGE:

○ English	○ Spanish	○ Japanese	○ Chinese	○ Italian	○ Hindi
○ Portuguese	○ Russian	○ French	○ Guatemalan	○ Tagalog	○ Arabic
○ Bosnian	○ Vietnamese	○ Laotian	○ German	○ Gujarati	

INSURANCE INFORMATION

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

SECONDARY INSURANCE INFORMATION (if applicable)

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

PATIENT NAME (please print)_____ DATE OF BIRTH _____

SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STAUS_____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)
NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)
NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY
NAME_____ LOCATION _____

PREFERRED LAB
We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

○ LabCorp	○ Other (specify):_____

LIVING WILL
Do you have a living will?

○ Yes	○ No	○ I'd like information about establishing a living will

DISCLOSURE OF CONFIDENTIAL INFORMATION

○ I choose to have voicemail left with minimal necessary information if I am not available, you may leave a message.	○ I choose to opt out of voicemail messages

You also have my permission to disclose information about my care to the following individual(s):

Name:_____Relationship:_____

Name:_____Relationship:_____

PATIENT SIGNATURE _____**DATE**_____

NAME:_____ Date of Birth:_____

PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.

The HIPAA (Health Insurance Portability and Accountability) Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We must abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer may review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.

Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.

Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.

Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must follow HIPAA guidelines.

Disclosures Requires by Law and Workers Compensation: We are allowed to disclose your health information to follow workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.

Abuse or Neglect: We may disclose your protected health information to the proper authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.

Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.

Research and Health Oversight: We are allowed to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are allowed to disclose your health information to a health oversight agency for activities authorized by law. Examples include audits, investigations, and inspections.

Written Authorization: Unless not required by law, your written authorization will be needed for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.

Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information about the patient. If there is not proper identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to be treated with respect and dignity and considerations in all of your interactions and communications. You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment to your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

You have the right to terminate your care at any time. Any outstanding balances will be due to the birth center and a refund, if applicable, will be issued after all insurance claims have processed. We will be happy to send your records to the provider of your choice with a signed records release.

PRIVACY COMPLAINTS and CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.

I have read the Privacy Notice and understand these policies and have had the opportunity to have my questions addressed.

PATIENT SIGNATURE:_____DATE_____

NAME:_____ Date of Birth:_____

OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____DATE_____

OR SIGNED FOR PATIENT BY _____RELATIONSHIP _____

Late Arrival

If a patient is more than **10 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day **if one is available.**
We will try to accommodate late-comers in the best manner possible but cannot compromise on the quality and timely care provided to our other patients.

- If a patient presents to the office **15 minutes late** for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment.
- If you are a **New Patient** and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 10-15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

Last Minute Cancelations and Missed Appointments

We require **24-hour notice** on all cancelations. As a courtesy to our patients, we attempt to confirm all appointments. We recognize that situations arise that are out of your control; however, it is imperative that you contact our office immediately to notify us of your cancelation in a timely manner.
Appointments canceled with less than a 24-hour notice or NO SHOW to your appointment will be subject to a $40.00 fee. ***We ask for your consideration and cooperation in scheduling your next appointment. Please understand that we are partners in your health care, and we are committed to offering you appropriate care when you need it.***

PATIENT SIGNATURE _____DATE_____

OR SIGNED FOR PATIENT BY _____RELATIONSHIP _____

NAME:_____ Date of Birth:_____

HIV TESTING IN PREGNANCY

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing, and understand that the result will become a part of my medical record.

PATIENT SIGNATURE _____DATE_____

DRUG TESTING IN PREGNANCY

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing, and understand that the results will become a part of my medical record.

PATIENT SIGNATURE _____DATE_____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____DATE_____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____DATE_____

AABC PERINATAL DATA REGISTRY

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE _____DATE_____

NAME:_____ Date of Birth:_____

DISPLAY NAME AND DUE DATE ON BULLETIN BOARD CONSENT

Some parents choose to display their first name and due date (as well as baby's name, date of birth and weight after delivery) on our bulletin board. The HIPAA privacy law requires that our office have written consent to display this information at our facility. HIPAA also requires that we allow you to choose an expiration date at which time your information will be removed from display.

- ○ I give permission to have my name, due date, baby's name, date of birth, and weight displayed on the bulletin board. It will be taken off display and provided to me at my six week postpartum visit (or destroyed)

- ○ I do not give the birth center permission to display information about me or my baby

SIGNATURE _____ DATE _____

PHOTO DISPLAY CONSENT

Some parents choose to send us photographs of their babies to display on the bulletin board. The HIPAA privacy law requires that our office have written consent to display any photographs that you send to our facility. HIPAA also requires that we allow you to choose an expiration date at which time your photograph will be removed from display and discarded.

- ○ I give permission to have any pictures I send to the birth center displayed on the bulletin board indefinitely

- ○ I do **not** give the birth center permission to display any photos I may send

- ○ I give permission to have any pictures I send to the birth center displayed on the bulletin board **until the following date** : _____

SIGNATURE _____ DATE _____

OB HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete ***ENTIRE*** form.

Name *(Last, First, M.I.):*	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Significant other's name:	He/She is ☐ present for pregnancy ☐ deployed ☐ incarcerated
Is this pregnancy planned or unplanned?	Do you have supportive family and friends?
Highest level of education:	Employed:
Who do you live with?	
What are your living arrangements? ☐ House ☐ Apartment ☐ Mobile Home ☐ Other	

PERSONAL MEDICAL AND SURGICAL HISTORY:

Please complete this portion of your health history in the ***patient portal PRIOR*** to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information***. If the patient portal is not completed, we may be required to reschedule or have you return for an additional visit to complete the appointment.***

What medications or supplements are you currently taking?_____

_____

Do you have allergies to any medications? _____

_____

FAMILY HEALTH HISTORY:

Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the ***patient portal PRIOR*** to your appointment.

OB/GYN HEALTH HISTORY

Last Menstrual Period:				
Last pap test:	Have you ever had an abnormal Pap test?			
Age period began?	Length of periods?	#days between periods?		
Any recent changes in your periods?			☐ Yes	☐ No
Are you sexually active?			☐ Yes	☐ No
Have you had more than one sexual partner in the last 6 months?			☐ Yes	☐ No
Do you use birth control?			☐ Yes	☐ No
Do you do regular self-breast exams?			☐ Yes	☐ No
Since your last period, have you had any illnesses, rash , fever or exposure to x-rays or toxic chemicals?			☐ Yes	☐ No
Were you born premature (<37 weeks)?			☐ Yes	☐ No
Are you currently breast feeding another baby?			☐ Yes	☐ No
Did your mother or sister have pre-eclampsia during their pregnancy?			☐ Yes	☐ No
Have you had a UTI (urinary tract infection) within 6 months of this pregnancy?			☐ Yes	☐ No

Have you experienced any of the following (check all that apply):

☐ Sexual or physical abuse or assault ☐ Domestic violence

☐ Emotional Abuse ☐ Childbirth trauma

☐ Major accident or illness or other traumatic event

Name:_____ Date of Birth:_____

Pregnancy History	Total # preg:____ # Premature births _____ #miscarriages/abortions: ____ # term births?_____

Baby date of birth day/month/year	Weight	Sex	Weeks pregnant	Type of birth	Length of labor	Complications/ Comments

NUTRITION & EXERCISE

Exercise	Do you exercise? Yes ☐ No ☐ What type of exercise do you enjoy? How often?		
Diet	Are you on any special diet or have dietary restrictions? If so what?	☐ Yes	☐ No
	Do you eat three meals a day?	☐ Yes	☐ No
	Do you have a working stove?	☐ Yes	☐ No
	Do you have running hot and cold water?	☐ Yes	☐ No
	Do you receive WIC?	☐ Yes	☐ No
	#meals you eat in an average day?	How much water a day?	How much caffeine a day?

How often do you eat?	**Never**	**2-3 times/ month**	**Once/week**	**2-3 times/wk**	**Once/day**	**2-3 times/day**
Fast food/restaurant food	☐	☐	☐	☐	☐	☐
Frozen meals	☐	☐	☐	☐	☐	☐
Home cooked meals	☐	☐	☐	☐	☐	☐
Beef	☐	☐	☐	☐	☐	☐
Chicken/.turkey	☐	☐	☐	☐	☐	☐
Pork	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐
Deli meat	☐	☐	☐	☐	☐	☐
Beans	☐	☐	☐	☐	☐	☐
Cookies/cakes/muffins	☐	☐	☐	☐	☐	☐
Other refined grains (white bread, rice pasta)	☐	☐	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐	☐
Fruits	☐	☐	☐	☐	☐	☐
Canned vegetables	☐	☐	☐	☐	☐	☐
Dairy (milk, cheese, butter)	☐	☐	☐	☐	☐	☐
Fried foods	☐	☐	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐	☐	☐
Meal replacements/shakes	☐	☐	☐	☐	☐	☐

Name:_____ Date of Birth:_____

Genetic Screening:			**Comments**
Are you older than 35 at the time of birth?	☐ Yes	☐ No	
Family history of thalassemia (Italian Greek, Mediterranean or Asian)	☐ Yes	☐ No	
History of Neural tube defect (meningomyelocele, spina bifida)	☐ Yes	☐ No	
Congenital heart defect	☐ Yes	☐ No	
Downs Syndrome	☐ Yes	☐ No	
Tay-sachs (Ashkenazi Jewish, Cajun, French-Canadian)	☐ Yes	☐ No	
Canavan Disease (Ashkenazi Jewish)	☐ Yes	☐ No	
Familial dysautonomia (Ashkenazi Jewish)	☐ Yes	☐ No	
Sickle cell disease or trait	☐ Yes	☐ No	
Hemophilia or other blood disorder	☐ Yes	☐ No	
Muscular dystrophy	☐ Yes	☐ No	
Huntington Chorea	☐ Yes	☐ No	
Mental retardation or autism	☐ Yes	☐ No	
Other inherited genetic of chromosomal disorder	☐ Yes	☐ No	
Maternal metabolic disorder (diabetes type 1 or PKU)	☐ Yes	☐ No	
You or baby's father had a child with birth defects not listed above	☐ Yes	☐ No	
Recurrent pregnancy loss or stillbirth	☐ Yes	☐ No	
Medications including supplements, vitamins, herbs, illicit drugs, recreational drugs or alcohol or exposure to toxic chemicals or X-rays since last menstrual period	☐ Yes	☐ No	
Infection history:			**Comments:**
Do you live with someone with TB or exposed to TB	☐ Yes	☐ No	
Have you had chicken pox or the vaccine?	☐ Yes	☐ No	
Have you had the HPV vaccine?	☐ Yes	☐ No	
Have you had COVID-19?	☐ Yes	☐ No	If so when:
Have you had the COVID Vaccine?	☐ Yes	☐ No	
Do you or your partner have a history of herpes	☐ Yes	☐ No	
Have you had a rash or viral illness since your last period?	☐ Yes	☐ No	
Do you have a history of hepatitis B or C?	☐ Yes	☐ No	
Do you live with or have sexual relations with anyone with a history of hepatitis B or IV drug users?	☐ Yes	☐ No	
Do you have a history of STD? (gonorrhea, chlamydia, HPV, HIV or syphilis	☐ Yes	☐ No	

Reviewed by: _____ Date: _____

Name:_____ Date of Birth: _____

Edinburgh Prenatal Depression Scale[1] (EPDS)

As you are pregnant, or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt in the PAST 7 DAYS, not just how you feel today.

Here is an example:

I have felt happy

- *Yes, all the time*
- *Yes, most of the time*
- *No, not very often*
- *No, not at all*

This would mean, "I have felt happy most of the time," during the past week.

Please complete the questions below the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all
2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never
4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often
5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all
6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all
8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all
9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never
10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Administered/Reviewed by: _____ Date: _____

[1]Source Cox, J L, Holden, J M and Sagovsky, R 1987. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry 150:782-786*

Date: _____ **Name**: _____ DOB: _____

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs (excluding alcohol and tobacco) during the past 12 months. Carefully read each statement and decide if your answer is "no" or "yes," then fill in the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter in excess of the directions, and any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents (e.g., paint thinners), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember, the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

1.	Have you used drugs other than those required for medical reasons?	☐	Yes	☐	No
2.	Do you abuse more than one drug at a time?	☐	Yes	☐	No
3.	Are you always able to stop using drugs when you want to?	☐	Yes	☐	No
4.	Have you had "blackouts" or "flashbacks" as a result of drug use?	☐	Yes	☐	No
5.	Do you ever feel bad or guilty about your drug use?	☐	Yes	☐	No
6.	Does your partner (or parents) ever complain about your involvement with drugs?	☐	Yes	☐	No
7.	Have you neglected your family because of your use of drugs?	☐	Yes	☐	No
8.	Have you engaged in illegal activities in order to obtain drugs?	☐	Yes	☐	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	Yes	☐	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	☐	Yes	☐	No

---------- *for office use only* ----------

DAST Score: _____

Plan of Care: _____

Reviewed by: _____

Skinner, H.A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors, 7,* 363-371

Hurt, Insulted, Threatened with Harm and Screaming (HITS)

Domestic Violence Screening Tool

Name:_____ DOB:_____ Date:_____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you?					
2. Insult or talk down to you					
3. Threaten you with harm?					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Reviewed by:_____

Each item is score from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse and should seek counseling or help from a domestic violence resource center.

Sherin, K. et.al. *HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting,* Family Medicine 1998;30(7):508-12.)

National Hotlines can connect clients to local resources and provide support.

For Free help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224

Teen Dating Abuse Hotline
1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)

Georgia 24 Hour Statewide Domestic Violence Hotline
1-800-33HAVEN (1-800-334-2836) https://gcadv.org/get-help/

THE MIDWIFE GROUP
Women's Health & Birth Center