CARE COORDINATION RECORD

SECTION 1 – GENERAL INFORMATION

Last name _____ First name _____ date of birth_____ age____

Address_____ City_____ Zip code_____

Telephone Number: Home_____ Cell_____ work_____

SS#_____ Insurance name_____ policy #_____

The best way to contact you: [ ] home [ ] work [ ] cell What is the best time: [ ] Day [ ] Evening

Ethnicity_____ Race_____ Marital Status_____

Father involved YES / NO Name _____ Phone #_____

Language: Reading – English____ Other_____ Speaking – English____ Other_____

Primary Care provider or Clinic Name _____

Dentist name _____ Last exam_____

SECTION 2 – CURRENT PREGNANCY

What was the first day of your last menstrual period? _____

When did you suspect you were pregnant? _____

Have you seen anyone for prenatal care: YES / NO If yes who _____date_____

Is this a planned pregnancy? YES / NO Current weight _____ pre-pregnancy weight_____

Any issues thus far with this pregnancy? [ ] Cramping [ ] bleeding [ ] nausea/vomiting [ ] Pain

SECTION 3 – PREGNANCY HISTORY

What pregnancy is this for you? _____ How many children do you have? _____

Any born before 37wks? YES / NO _____ weighing less than #5 8oz? YES / NO _____

Miscarriages: YES/ NO_____ Have you been pregnant in the last year: YES / NO _____

Name of hospital for past delivery _____

CARE COORDINATION RECORD

SECTION 4 – CONCERNS

1. How many people can you count on when you need help? [ ] 0 [ ] 1-2 [ ] 3+

2. How do you rate your current stress level? [ ] Low [ ] Medium [ ] High

3. How do you deal with issues and stress in your life? _____

4. Do you feel safe at home? YES NO

5. Do you have problems with depression, or received counseling or medication for any mental health concerns? Past or present? YES NO

6. During the past month, have you had little interest in doing things? Or have your been bothered by feeling down or depressed? YES NO

7. Before pregnancy did you smoke? E-cig or vape YES NO
   if yes, indicate average number of cigarettes smoked per day_____

8. Since pregnant, have you smoked cigarettes? E-cig, or vape? YES NO

9. Does anyone in the household smoke? E-cig or vape? YES NO

10. Three months before this pregnancy, did you use any form of alcohol? YES NO
    If yes, indicate the number of drinks per week _____

11. Since you have been pregnant, have you used alcohol? YES NO

12. In the past year have you used street, prescription, or OTC drugs? YES NO
    If yes, list medication _____

Name_____ DOB_____

CARE COORDINATION RECORD

13. Have you ever been physically, sexually, emotionally/verbally abused by your partner or someone that was close to you? YES NO

14. Have you had any housing issues/problems in the past three months? YES NO

15. Do you have transportation or childcare issues, or other problems that would keep you from making your health care appointments? YES NO

16. In the past month have you missed meals, not ate when hungry, or used a food bank because there was not enough food in the house or no money to buy food? YES NO

17. How may times a day do you brush your teeth? _____ Floss? _____

18. Who can you count on for help with everyday activities, such as childcare, meals or transportation? _____

19. Do you have any worries or concerns in your life now? YES NO

    if yes what are they _____

    _____

20. What would you like us to help you with during your pregnancy?

    _____

    _____

    _____

    _____

    _____

Sign_____ DATE_____

Nurse Signature_____ DATE_____

Name_____ DOB_____

Nutritional Consult on Intake

Name _____ DOB _____ EDC _____

1. What was your weight before pregnancy? _____

2. Are you worried about gaining weight during pregnancy? _____ yes _____ no

   If yes, why? _____

3. Do you follow a special diet at this time? (Check all that apply)

   ☐ Gluten free ☐ Kosher ☐ Lactose Intolerance ☐ Halal

   ☐ Vegetarian ☐Vegan ☐ Other _____ please specify

4. Do you have any food allergies? _____ yes _____ no

   If yes, please specify _____

5. Are you experiencing any of the following?

☐ nausea ☐ vomiting ☐ heartburn ☐ constipation ☐ decreased appetite ☐ none

6. Which of these do you take?

☐prenatal vitamins ☐ iron supplement ☐ antacids ☐ herbal supplement

If you are taking a prenatal vitamin, please specify the brand/name of the prenatal vitamin:
_____

7. Do you have any history of the following? Please check all that apply

____ Eating Disorder _____ Diabetes _____ Crohn's Disease

____ Ulcerative Colitis ____ Gastric Bypass Surgery

8. How do you plan to feed the infant? _____

9. Is there anything you'd like to discuss with the dietitian?_____
_____
_____
_____

GRAND VIEW HEALTH
700 Lawn Avenue
Sellersville, PA 18960

EDINBURGH DEPRESSION SCALE*

Also known as the
Edinburgh Postnatal Depression Scale (EPDS)*

Instructions: Patients please read each question and choose the most accurate answer.
Please answer all questions as best as possible.
The answers to these questions reflect your feelings over the past 7 days.

Date _____

1. I have been able to laugh and see the funny side of things:
   - ☐ 0 - As much as I always could
   - ☐ 1 - Not quite as much now
   - ☐ 2 - Definitely not as much now
   - ☐ 3 - Not at all

2. I have looked forward with enjoyment to things:
   - ☐ 0 - As much as I ever did
   - ☐ 1 - Rather less than I used to
   - ☐ 2 - Definitely less than I used to
   - ☐ 3 - Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
   - ☐ 3 - Yes, most of the time
   - ☐ 2 - Yes, some of the time
   - ☐ 1 - Not very often
   - ☐ 0 - No, never

4. I have been anxious or worried for no good reason:
   - ☐ 0 - No, not at all
   - ☐ 1 - Hardly ever
   - ☐ 2 - Yes, sometimes
   - ☐ 3 - Yes, very often

5. I have felt scared or panicky for no very good reason:
   - ☐ 3 - Yes, quite a lot
   - ☐ 2 - Yes, sometimes
   - ☐ 1 - No, not much
   - ☐ 0 - No, not at all

6. Things have been getting on top of me:
   - ☐ 3 - Yes, most of the time I haven't been able to cope at all
   - ☐ 2 - Yes, sometimes I haven't been coping as usual
   - ☐ 1 - No, most of the time I cope quite well
   - ☐ 0 - No, not at all

7. I have been so unhappy that I have difficulty sleeping:
   - ☐ 3 -Yes, most of the time
   - ☐ 2 -Yes, sometimes
   - ☐ 1- Not very often
   - ☐ 0 - No, not at all

8. I have felt sad or miserable:
   - ☐ 3 - Yes, most of the time
   - ☐ 2 - Yes, quite often
   - ☐ 1 - Not very often
   - ☐ 0 - No not at all

9. I have been so unhappy that I have been crying:
   - ☐ 3 - Yes, most of the time
   - ☐ 2 - Yes, quite often
   - ☐ 1 - Only occasionally
   - ☐ 0 - No, never

10. The thought of harming myself has occurred to me:
    - ☐ 3 - Yes, quite often
    - ☐ 2 - Sometimes
    - ☐ 1 - Hardly ever
    - ☐ 0 - Never

Total score: _____

Scored by: _____ Date: _____

Language line # if used _____

GVH GRAND VIEW HEALTH

PATIENT INFORMATION

Name (Last, First, Middle)	Employer Name
Date of Birth: Sex: ☐ M ☐ F ☐ Unk	Employer's Address
Address	Employer's Phone #
City State Zip	Employer Status ☐ Full time ☐ Part time ☐ Retired ☐ Active Military ☐ Self Employed ☐ Unemployed
Email	Occupation
Primary Care Physician:	Pharmacy Name and Location
Referring Physician	

Communication Preferences

Phone Numbers

Cell:	Marital Status _____
Home:	Preferred Language _____
Work:	Interpreter Needed: ☐ Yes ☐ No
Preferred Phone # ☐ Cell ☐ Home ☐ Work	Ethnicity: ☐ Non Hispanic ☐ Other _____ ☐ Hispanic ☐ Unknown
OK to leave voice mail regarding appointment, clinical, or financial information? ☐ Yes ☐ No	Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other ☐ Patient Declined

Emergency Contact

Name (Last, First, Middle):	Permission to Disclose Healthcare Information ☐ Yes ☐ No
	Regarding Appointments? ☐ Yes ☐ No
Relationship to Patient:	Regarding Clinical Information? ☐ Yes ☐ No
Phone # ☐ Cell ☐ Home ☐ Work	Regarding Financial Information? ☐ Yes ☐ No

Person Financially Responsible ☐ check here if self

Name (Last, First, Middle)	Relationship to Patient
Address	Home Phone
City State Zip	Cell Phone

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name
Subscriber Name	Subscriber Name
Subscriber DOB	Subscriber DOB
Policy Number	Policy Number
Group Number	Group Number
Effective Date	Effective Date

Patient or Guardian Signature _____ **Date** _____

GVH GRAND VIEW HEALTH

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I, _____ (Print Name) request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy with _____(Insurance Company) or benefit plan to be paid directly to Grand View Health for services and goods provided by Grand View Health.

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan for services and goods provided by Grand View Health.
- In event that I fail to make full payment or fail to comply with other payment arrangements made with Grand View Health's approval, I understand appropriate collection measure may be initiated.
- If my account is referred to an attorney or agency for collections of any unpaid balances for which I am responsible, I understand that I will also be responsible for all collection costs, including reasonable attorney's fees and court costs.
- My obligations to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
- That I am responsible to know and understand what services are covered under my insurance policy.

RELEASE OF INFORMATION

I authorize GVH and/or their agents:

- To release to my insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to process related health claims, receive payment or to obtain authorization for services, supplies and equipment in accordance with HIPAA standards..
- To request and to receive directly, on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against my insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner furnishing health care services to me or receive information from them in accordance with HIPAA standards.

STATEMENT OF ASSISTANCE

I agree:

- To assist GVH in collections that may be due or payable under my insurance policy or benefit plan for the service, supplies and equipment provided.
- To provide any additional information needed to process the claim for payment.
- That a photocopy or other reproduction of this document shall be considered as valid as the original.

By signing below I am certifying that the information on this form is correct and current:

_____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date

_____ _____

Signature of Witness | Date

If the patient is unable to sign upon arrival, state the reason: _____

GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
215-453-4000
www.gvh.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Privacy Officer at Grand View Health, on this organization's website, or by requesting one at this organization's offices.

_____
Date

_____
Signature

_____
Print or Type Name

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____
Signature Relationship

GVH GRAND VIEW HEALTH

GVH GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4850

MyGVH.org

Patient Portal Enrollment Form

Please complete the information below. A Grand View Health representative will set up your portal account and you will receive an email to the email address provided below with instructions to complete your enrollment within the next 2-3 business days.

I understand that patient information within the portal may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

Should you like to access patient information for someone other than yourself, please fill out an Authorization for Proxy Access to GVH Patient Portal form.

Patient Name _____

Address _____City_____State_____ Zip Code _____

Date of birth (month/day/year) _____/_____/_____

Phone Number: _____

Medical Record # (if available) _____

Email address _____

Verify Email address _____

Signature _____ Date _____

FOR STAFF USE ONLY

Patient name as shown in EMR: _____

Medical Record # as shown in EMR: _____

DOB as shown in EMR: _____

ID Verified by: _____

Enrollment completed by: _____
(Print Name)

- ☐ Patient Identification
- ☐ Photo ID
- ☐ POA Provided
- ☐ Office
- ☐ Patient Registration
- ☐ Health Information Management

Please present completed Patient Portal Enrollment Form to the Health Information Management Department with photo ID.