OB Registration Packet

Please complete every page **ENTIRELY** prior to your scheduled OB REG appointment time.

If packet is not completed, registration appointment may need to be rescheduled.

**Tripler Army Medical Center OB and Schofield Barracks**

OB Appointment Line: 1-888-683-2778, Option 3, 7, then 1 or 433-2778, Option 3, 7, then 1 (old number)
Dear OB Patient,

**Congratulations** from the staff of Tripler Army Medical Center, Schofield Barracks, NHC Hawaii Kaneohe Bay and Makalapa OB/GYN Clinics! We would like to share what you can expect when receiving care with us, as well as explain the different care options that are available to you.

The first appointment that must be completed by all patients is the OB Registration Appointment. This appointment is conducted by a nurse who will review your completed registration packet, schedule your physical appointment, order laboratory tests, and conduct teaching regarding nutrition, exercise, support services, and signs to report immediately. At this appointment, your nurse will ask if you have considered your prenatal care options. The options available to you are:

1. **OB Physician Care:** available for complicated and uncomplicated care at Tripler Army Medical Center for the duration of your pregnancy as well as your delivery.
2. **Nurse Practitioner Care:** available for uncomplicated care at Tripler Army Medical Center and Schofield Barracks for your pregnancy. Your delivery will be managed by a physician.
3. **Certified Nurse Midwife:** available for uncomplicated care at Tripler Army Medical Center for the duration of your pregnancy as well as your delivery. You must meet specific criteria in order to be enrolled. This program is limited to women who have a low risk of needing any intervention during delivery.
4. **Centering Pregnancy:** available for uncomplicated care at Tripler Army Medical Center. This form of prenatal care is conducted in a group, with time included for one on one time with the provider. These groups are facilitated by a Certified Nurse Midwife or a Nurse Practitioner. At the group sessions, you will conduct a physical check-up, learn valuable self-care and infant care skills, discuss common pregnancy complaints and solutions, and build a strong sense of community with the other women in the group. This is an exciting program with many benefits to the participants. Please see our homepage, Facebook page, or call our Centering Coordinator for more information. Our Centering Coordinator can be reached at 808-433-4593, or by calling the main line at 1-888-683-2778 option 3, 7 then 1, and asking for the Centering Coordinator.

Your next appointment will be conducted with a Physician, Nurse Practitioner, or a Certified Nurse Midwife. Your ultrasound will be done at 20 weeks.
If you have any questions or concerns, please contact our OB Team Advice Nurses at:

~ Ginger Team Nurse: 433-5933  
~ Hibiscus Team Nurse: 433-3671  
~ Orchid Team Nurse: 433-4941  
~ Plumeria Team Nurse: 433-3337

Please leave a message with your name, your sponsor’s social security number, your phone, and why you are calling.

The Same Day Evaluation Clinic (SDEC) at Tripler is available for any of the following problems:

* Vaginal bleeding with cramping  
* Repeated nausea and vomiting for greater than 24 hours  
* Burning on urination  
* Fever greater than 100.5

Same Day Evaluation Clinic Hours: M, W, Th, F 0800-1500, *Tue 0800-1100.

Please go to the Emergency Department for any issues after hours or for the following emergencies:

* Major car accident  
* Broken bones  
* Chest pain  
* Trouble breathing  
* Non-obstetrical emergencies

To SCHEDULE or CANCEL an appointment, please call;  
~ 1-888-683-2778, option 3, 7, then 1  
~ 433-2778, Option 3, 7, then 1 (old number)

Your appointment is scheduled on __________________________ at __________________________  
(date) (time)  
with __________________________ at Tripler Army Medical Center / Schofield Barracks.  
(provider)

Please fill this packet out COMPLETELY. If you are transferring care (have received care for this pregnancy at another facility) please bring your records with you. A copy will be made and the original will be given back to you.

*We look forward to meeting you!*
Childcare Options

Children are welcome at many of the appointments that you will attend during your prenatal care; however, we ask that you find childcare for the following appointments:

1. **Anatomy Ultrasound (20 week ultrasound)**
2. **Any appointments in the Antepartum Diagnostic Center (ADC) to include non-stress tests, fluid checks, dating ultrasounds, etc.**
3. **CenteringPregnancy® sessions**

We understand that it can be very difficult to arrange for childcare for these appointments. Here are some of the childcare options available to you:

1. **Armed Services YMCA Children’s Waiting Room at Tripler AMC** - Care is available in 2 hour increments from Monday-Friday, 8am-12pm, and 12pm-3:30pm for children 6 weeks to 12 years old. Children must be registered, in good health, and up-to-date on their shots. Children must wear closed-toe shoes. Reservations are preferred. Please call 808-433-3270 for registration and reservation information. This program is run on monetary donations, please ask your Nurse for current cost.

2. **Child Development Centers** - Care is provided on a part-time, full-time, after-school, and drop-in basis, as space is available. Children must be registered and be up-to-date on their shots. Registration can be done at Schofield Barracks (Army, 655-5314), Aliamanu Military Reservation (Army, 833-5393), Hickam (Air Force, 449-9880), Pearl Harbor (Navy, 473-2669), or MCBH (Marines, 257-8354). Please visit [www.himwr.com/child-development-centers](http://www.himwr.com/child-development-centers), [www.greatlifehawaii.com](http://www.greatlifehawaii.com), or [www.mccshawaii.com/cdc](http://www.mccshawaii.com/cdc) for more information.

3. **PATCH** - PATCH is Hawaii’s statewide child care resource and referral agency. This agency provides parents with information and resources needed when looking for quality care for their children. This is a free service. For more information call 839-1988 or visit [www.patchhawaii.org](http://www.patchhawaii.org).

If you are unable to arrange childcare and will miss your appointment, please call our appointment line as soon as possible to cancel your appointment and to reschedule.
OB Registration
Please fill this form out completely before your appointment with the nurse.

<table>
<thead>
<tr>
<th>Your Last Name</th>
<th>First Name</th>
<th>Sponsor's SSN</th>
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<tr>
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<thead>
<tr>
<th>Marital Status</th>
<th>Ethnicity</th>
<th>Primary Language</th>
<th>Your Date of Birth</th>
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</thead>
<tbody>
<tr>
<td>Married</td>
<td>Caucasian</td>
<td>English</td>
<td>/      /</td>
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<tr>
<td>Single</td>
<td>African American</td>
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<td>Divorced</td>
<td>Filipino</td>
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<td>Widowed</td>
<td>Korean</td>
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<td>Japanese</td>
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<td>Samoan</td>
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<tr>
<th>Religious Preference</th>
<th>Check one: (you are)</th>
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<tbody>
<tr>
<td></td>
<td>Dependent</td>
</tr>
<tr>
<td></td>
<td>Active Duty (O-1, E-1, etc)</td>
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<tr>
<th>Sponsor's:</th>
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<tr>
<td>Branch of Service:</td>
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<thead>
<tr>
<th>Husband / Sponsor's Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Check one</th>
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<tr>
<th>Father of Baby is</th>
<th>Father's Ethnicity:</th>
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<th>Address:</th>
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<tr>
<td>Street:</td>
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<tr>
<td>City, State, Zip</td>
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<tr>
<td>Home Phone</td>
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<thead>
<tr>
<th>Smoking: (per day)</th>
<th>Never</th>
<th>Recently Quit</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
<th>Very Heavy</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>&lt; one pack</td>
<td>1-1.5 pack</td>
<td>1.5-2 packs</td>
<td>&gt;2 packs</td>
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<tr>
<th>Illicit Drug Used:</th>
<th>Never</th>
<th>Recently Quit</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
<th>Very Heavy</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1-2 times/year</td>
<td>34</td>
<td>45</td>
<td>&gt;5</td>
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<tr>
<th>Alcoholic Beverages:</th>
<th>Never</th>
<th>Recently Quit</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
<th>Very Heavy</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1-2 drinks/month</td>
<td>34</td>
<td>45</td>
<td>&gt;6</td>
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<tr>
<th>Caffeinated Beverages:</th>
<th>Never</th>
<th>Recently Quit</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
<th>Very Heavy</th>
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<td></td>
<td></td>
<td></td>
<td>1-2 times/day</td>
<td>34</td>
<td>45</td>
<td>&gt;6</td>
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<tr>
<th>I am taking:</th>
<th>Prenatal Vitamins</th>
<th>Iron Supplements</th>
<th>Folic Acid</th>
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</table>

Please list any other medications, vitamins or herbal supplements that you take on a regular basis.
Please let us know if you have any problems with the following parts of your body by checking the block and giving a short description, to include dates.

GENERAL
HEAD/MIGRAINES
EYES/GLASSES/CONTACTS
EAR
NOSE
NECK
THROAT
LUNGS
HEART
STOMACH/INTESTINES/BOWEL MOVEMENTS
URINARY/KIDNEYS/URINARY TRACT INFECTIONS
GYN/UTERUS/OVARIES/CERVIX/ABNORMAL PAP SMEARS
BLOOD/ANEMIA/SICKLE CELL/HEPATITIS
LYMPH
MUSCLES/BACK
NEURO/PSYCH/ANXIETY/DEPRESSION/EATING DISORDERS
HISTORY DRUG/ALCOHOL ABUSE TREATMENT
OTHER

Please check the box if you have ever been treated for any of the following: (Include dates)

HYPERTENSION/PRE-ECLAMPSIA
HERPES
SEXUALLY TRANSMITTED DISEASES
BLOOD TRANSFUSION
MORE THAN TWO URINARY TRACT INFECTIONS IN ONE YEAR
SEIZURE
THYROID PROBLEMS
ASTHMA
DIABETES
CARDIAC PROBLEMS
PULMONARY PROBLEMS / TUBERCULOSIS (TB)

Do you own any cats? YES NO

Please check the box if you (the mother) has a family history of any of the following. If you do, state the relationship to you. Remember, we only need to know if it is on your side of the family.

TWINS
BIRTH DEFECTS
DIABETES
CANCER
HEART DISEASE
HIGH BLOOD PRESSURE
Are you allergic to any food or medication?  YES  NO
If yes, please write what you are allergic to and what happens to you.

I have had the following childhood illnesses:
(Please check the appropriate box or boxes.)

NONE  CHICKEN POX  MEASLES  MUMPS  RHEUMATIC FEVER

Please list any past operations/surgeries that you have had. Include the month and year they occurred.

First day of your last menstrual period:  Height:  Usual Weight:
Including this pregnancy, how many times have you been pregnant? 
How many children do you have now? 
How old were you when you had your first period? 
Are your periods  REGULAR  IRREGULAR
How often did your periods occur? Every  days.
Rate the amount of pain that you experience with your menstrual cycle.

NONE  MILD  MILD-MODERATE  MODERATE  SEVERE  IRREGULAR
How many days do you bleed for during your menstrual period?

Past Pregnancies: Please fill out the chart below. Include any miscarriage or elective terminations that you have had.

<table>
<thead>
<tr>
<th>Date</th>
<th>How many weeks you were at delivery</th>
<th>Hours of labor</th>
<th>Type of Anesthesia Used</th>
<th>Vaginal, C/S, Forceps, Vacuum</th>
<th>Hospital and State</th>
<th>Sex of Baby</th>
<th>Weight</th>
<th>Any Complications/Hospitalizations During Pregnancy/Medication</th>
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</table>
Have you ever had a positive Tuberculosis or TB Tine Test? YES NO If yes, when: ________________

Were you born outside of the United States? YES NO If yes, where: ________________

Have you ever lived outside of the United States for more than 30 days? YES NO

Have you ever had active TB or lived with someone with active TB? YES NO

Have you ever taken any medications for TB? YES NO If yes, when: ________________

If so, what medication(s) ________________ How long? ________________

Is this a planned pregnancy? Yes No

Are you experiencing any: NAUSEA VOMITING CRAMPING BLEEDING

How will you feed your baby? BREAST FEED BOTTLE FEED UNDECIDED

How would you describe your appetite? ________________

Are you on any kind of special diet? NO YES. What kind? ________________

Do you have any food cravings? NO YES. They are ________________

Do you avoid any foods? NO YES. They are ________________

How many times do you eat in one day? ________________

What topic(s) do you want/need education on?

<table>
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<tr>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Prenatal Care</td>
<td>Childbirth Preparation Classes</td>
<td>Breastfeeding</td>
<td>Infant Care</td>
<td>Labor and Delivery Tour</td>
<td>WIC</td>
<td>Sibling Classes</td>
<td>Home Visiting Nurse</td>
</tr>
</tbody>
</table>

What is the best method of learning for you? Reading Videos Computer Demonstration

What is the highest school grade that you have completed? ________________

Do you have any chronic pain issues/concerns? YES NO If so, explain: ____________________________________________

Do you have any financial hardships that prevent you from getting medical care? YES NO

Do you have any cultural, language or religious preferences that would affect your care? YES NO If yes: ____________________________________________

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Do you have an Advance Medical Directive? YES NO

If no, are you interested in receiving information? YES NO

All information gathered IAW The Privacy Act of 1974.
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For the use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

TAMC Prenatal Genetic Screen*

1. Will you be 35 years or older when the baby is due? Yes  No

2. Have you, the baby’s father, or anyone in either of your families ever had the following disorders?
   a. Down Syndrome  Yes  No
   b. Other chromosomal abnormality  Yes  No
   c. Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly  Yes  No
   d. Hemophilia  Yes  No
   e. Muscular dystrophy  Yes  No
   f. Cystic fibrosis  Yes  No
   g. If yes, indicate the relationship of the affected person to you or the baby’s father:

3. Do you or the baby’s father have a birth defect?
   a. If yes, who has the defect and what is it?  

4. In any previous marriages, have you or the baby’s father had a child, born dead or alive,  with a birth defect not listed in question 2 above? Yes  No

5. Do you or the baby’s father have any close relatives with mental retardation?
   a. If yes, indicate the relationship of the affected person to you or the baby’s father:  
   b. Indicate the cause, if known:

6. Do you, the baby’s father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes  No
   a. If yes, indicate the condition and the relationship of the affected person to you or the baby’s father:

7. In any previous marriages, have you or the baby’s father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?
   a. Have either of you had a chromosomal study? Yes  No
   b. If yes, indicate who and the results:

8. If you or the baby’s father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes  No
   a. If yes, indicate who and the results:

9. If you or the baby’s father are black, have either of you been screened for sickle cell trait? Yes  No
   a. If yes, indicate who and the results:

10. If you or the baby’s father of Italian, Greek, or Mediterranean background, have either of you been tested for β-thalassemia? Yes  No
    a. If yes, indicate who and the results:

11. If you or the baby’s father are of Philippine or Southeast Asian ancestry, have either of you been tested for α-thalassemia? Yes  No
    a. If yes, indicate who and the results:

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (including non-prescription drugs) Yes  No
    If yes, give name of medication:

Prepared by (signature & title)  DEPARTMENT/SERVICE/CLINIC  DATE (YYYYMMDD)

PATIENT’S IDENTIFICATION (For a typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)  HISTORY/PHYSICAL  FLOW CHART
OTHER EXAMINATION  OTHER (specify)
OR EVALUATION  DIAGNOSTIC STUDIES
TREATMENT
The New Parent Support Program

The New Parent Support Program helps military parents, including expectant parents, transition successfully into parenthood and provides a nurturing environment for their children. The program offers support and guidance by helping parents:

- **Build strong, healthy bonds** with their infants and toddlers that will lay the foundation for their social and emotional development
- **Manage the demands of parenting**, especially when impacted by deployments and other military operations
- **Remain flexible and responsive** when navigating daily life
- **Build a strong support network**
- **Respond to infant and toddler behavior sensitively** and be attuned to their developmental needs
- **Find services** in the local community in time of need

**Types of services provided**

The New Parent Support Program’s staff consists of nurses, social workers and home visitation specialists, and is supervised and monitored at the installation level by the Family Advocacy program manager. The program focuses on providing one-on-one support for new and expectant parents through home visits, but some installations may offer parenting classes and groups. Services vary by service branch and by installation, but they can include:

- Home visits
- Referrals to other resources
- Prenatal classes
- Parenting classes
- Playgroups

**Eligibility and Enrollment**

The New Parent Support Program’s services are free to active-duty service members and their families who meet one of the following criteria:

- **Expecting their first child**
- **Have at least one child younger than 3 years old (Army, Navy and Air Force)**
- **Have at least one child younger than 5 years old (Marine Corps)**

Service members who have separated from active duty may still be eligible for the program depending on the nature of the separation. If you have access to a military treatment facility, you may be entitled to program benefits on a space-available basis.
Page Intentionally Left Blank
# NEW PARENT SUPPORT PROGRAMS HAWAII – CASE REFERRAL

**To:** (name and location)  
**New Parent Support Programs Hawaii (NPSP Hawaii)**  
Air Force: 449-0175  
Army: 655-1670  
Marine Corps: 257-8803  
Navy: 473-4222 x 233  

**From:** (name and location)

<table>
<thead>
<tr>
<th>1. NAME OF PATIENT (Last, First, Middle Initial)</th>
<th>2. ADDRESS OF PATIENT (Give specific directions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. DATE OF BIRTH</td>
<td>4. AGE</td>
</tr>
<tr>
<td>5. HOME PHONE</td>
<td></td>
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<tr>
<td>6. PATIENT SSN:</td>
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</table>

<table>
<thead>
<tr>
<th>7. NAME OF SPONSOR (Last, First, Middle Initial)</th>
<th>8. SPONSOR’S GRADE AND SSN</th>
<th>9. BRANCH OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. ORGANIZATION</td>
<td>11. WORK PHONE</td>
<td>12. MARITAL STATUS</td>
</tr>
<tr>
<td>13. FIRST TERM ENLISTMENT? ✓ YES ☐ NO</td>
<td>14. SPONSORS LAST DEPLOYMENT:</td>
<td>15. NUMBER OF PREGNANCIES: NUMBER OF CHILDREN:</td>
</tr>
<tr>
<td>16. ESTIMATED DUE DATE: ☐ Y / ☑ N</td>
<td>Pending Deployment: Y / N</td>
<td>Total number and attach face sheet with ages</td>
</tr>
<tr>
<td>CHILDREN WITH SPECIAL NEEDS: Y / N</td>
<td></td>
<td>IF YES, SPECIFY:</td>
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**17. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize the release of the medical information relevant to this referral to the New Parent Support Program or the Armed Services (Well Baby) YMCA, Hawaii for planning of prenatal health services and parenting support.

SIGNATURE OF PATIENT (or person authorized to consent for patient) ___________________________ DATE ________________

**18. REASON FOR REFERRAL; OTHER SIGNIFICANT DATA**

1. Number of Pregnancies: ______  
   Number & Ages of Children: ____________________________________________________________

2. How are you feeling about being pregnant? ____________________________  
   Partner: _________________________

3. What concerns or worries do you have? _____________________________________________

4. What experiences do you have caring for a newborn baby? ____________________________

5. Do you have parenting concerns? __________________________________________________

6. Who do you have that you can depend on for help? _________________________________

7. What do you do when you feel stressed or “frazzled”? ______________________________

8. In a few words, what was your childhood like? ______________________________________

9. Have you ever been emotionally abused? ☐ No ☐ Yes  
   When: ________________________  
   By Whom: _____________________

10. Have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt in the past or during your pregnancy?  
    ☐ No ☐ Yes  
    When: ________________________  
    By Whom: _____________________

11. Have you ever experienced forced sexual activities?  
    ☐ No ☐ Yes  
    When: ________________________  
    By Whom: _____________________

12. If you were emotionally, physically, or sexually abused, how does it affect you now?  
    ____________________________________________________________

13. Have you had counseling? ☐ No ☐ Yes  
    Do you want counseling now? ☐ No ☐ Yes

14. Do you feel safe in your home/personal relationship? ☐ No ☐ Yes

15. Have you had any previous involvement with FAP or Child Protective Services for child abuse or neglect? ☐ No ☐ Yes  
    If Yes, when? ________________________

16. Do you or your spouse have a history of mental illness, i.e. depression? ☐ No ☐ Yes
This form in and of itself DOES NOT constitute a contract with the Army for payment of services to be rendered.

19. REPORT OF FINDINGS AND RECOMMENDATIONS

DATA REQUIRED BY THE PRIVACY ACT OF 1974


2. PRINCIPAL PURPOSE(S): Provides a means for medical and allied medical personnel to refer individuals and families for Army community health nursing services.

3. ROUTINE USES:
   a. To refer patients or family units to other military and civilian health and welfare agencies or to Army community health nurses at other military installations.
   b. A case referral which contains medical information requires written consent of the patient or legal representative prior to release to a civilian agency.
   c. A doctor’s signature is required when medication and/or treatments are ordered.
   d. To provide continuity of care, minimize duplication of effort and furnish accurate information to other health care providers.
   e. When case is completed or inactive, one copy of record is returned to the initiator (item 2, above) and duplicate copies of record are destroyed when no longer needed.

4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary however failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care providers.
Welcome to the T AMC OB/GYN Clinic!

Thank you for your interest in the Centering Pregnancy® Program!

The Centering Pregnancy® Program is an innovative and cutting-edge way to get prenatal care. You will meet with other moms due in the same month for ten sessions during your second and third trimesters, on a schedule similar to traditional prenatal care. These sessions are conducted in a group and replace one-on-one prenatal visits with your provider. During each two-hour session you will assess your health status by taking your weight and vital signs, have a health assessment by the provider (a Certified Nurse Midwife or Nurse Practitioner), and participate in a group discussion of pertinent prenatal issues. Attendance at every session is a requirement for participation in the program (an exception will be made for emergencies). One support person is welcome to attend sessions with you.

Sessions are conducted in a conference room, not an examination room, with a relaxed and comfortable atmosphere. You will get to spend two hours with a provider instead of the usual 15 minutes, so those questions that you forget to ask are a thing of the past! Sessions begin and end ON TIME, so no more delays to your schedule, AND you will know when all your appointments are ahead of time. If an issue arises that requires a private examination, every attempt to accommodate you THAT DAY will be made.

Enrollment occurs at or after your OB PE appointment. Please let your provider know at your OB PE appointment if you would like to enroll, sessions are currently held at Tripler and Schofield Barracks.

We are very excited to bring this wonderful program to our patients, and hope that you will continue to consider Centering Pregnancy for you and your family.

Please feel free to contact me if you have any questions or concerns about the Centering Pregnancy® Program. Hope to see you soon!

Aloha,

Centering Pregnancy® Coordinator
TAMC OB/GYN Outpatient Clinic
TAMC’S Centering Pregnancy® Program

808.433.4593

Patient’s Name: ____________________________________________________________

Spouse’s/Support Person’s Name: _____________________________________________

Patient’s DOD ID#: __________________________________________________________

Patient’s FMP/Last 4 of Sponsor’s SSN: _________________________________________

Is this your first baby? (please circle) Yes No

Daytime Phone Number: _______________________________________________________

Please allow us to contact you by email. Your email address will be used by the Centering Coordinator to communicate information regarding sessions, deliver letters from the Centering Pregnancy® Coordinator, and to contact you regarding last minute changes to sessions in case you cannot be reached by phone.

EmailAddress: ______________________________________________________________

Due Date (EDC or EDD): _______________________________________________________

OB PE APPT Date & Time: ____________________________________________________

OBPE Provider: _____________________________________________________________

Application
TRIPLER TROLLEY
Hours: 0615 to 1645
Phone: 433-5722

RED ROUTE
1 - E-Wing
2 - Oceanside Entrance
3 - D-Wing
4 - Lower D Lot
5 - Lower A Lot
6 - Lower A Lot
7 - Lower E Lot

BLUE ROUTE
1 - Mountainside Entrance
2 - Emergency Department
3 - BLD 215 P/lot
4 - Army Hotel Bldg 220
5 - Army Hotel Parking Lot
6 - Housing Area
7 - Fisher House I
8 - Fisher House II
9 - TAMC Gym
10 - VA ACC