Tripler Army Medical Center

&

Schofield Barracks

Department of Obstetrics

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: 433-2778, Option 7, then option 1

Dear OB Patient,

Congratulations from the staff of Tripler Army Medical Center and Schofield Barracks 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 808-433-2778 option 7 then option 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 **Advice Nurse at 808-433-2778, option 7 then option 3.** 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 0800-1230.
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 an appointment, please call 808-433-2778, extension 7, 1

To CANCEL an appointment, please call 808-433-1177 or 808-433-1164

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. *Centering 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.
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, www.greatlifehawaii.com, or 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.

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.

Your Last Name | **First Name** | **THE SPONSOR'S SSN**

Marital Status

Married
Single
Divorced
Widowed

Ethnicity

Caucasian
African American
Filipino
Korean
Japanese
Samoan
Chinese
Mexican
Hispanic
Native American
Pacific Islander
_____

Primary Language

English
_____

Your Date of Birth

___/____/___

Religious Preference

_____

Check one: (you are)

Dependent
Active Duty _____
(O-1, E-1, etc)

Sponsor's:

Branch of Service: _____

Base/Post Stationed at: _____

Military Unit: _____

Husband / Sponsor's Last Name | **First Name** | **Date of Birth** | **Check one**

___/____/___

Dependent
Active Duty _____
(O-1, E-1, etc)

Father of Baby is

Aware of my pregnancy
Supportive of pregnancy

Father's Ethnicity: _____

Address:

Street

City, State, Zip

Home Phone | **Work Phone** | **Email**

PCS/DEROS:

Please rank the following according to your daily use:

Smoking: (per day)	Never	Recently Quit	Light < one pack	Moderate 1-1.5 pack	Heavy 1.5-2 packs	Very Heavy >2 packs
Illicit Drug Used:	Never	Recently Quit	Light 1-2 times/year	Moderate 3-4	Heavy 4-5	Very Heavy >5
Alcoholic Beverages:	Never	Recently Quit	Light 1-2 drinks/month	Moderate 3-4	Heavy 4-5	Very Heavy >5
Caffeinated Beverages:	Never	Recently Quit	Light 1-2 times/day	Moderate 3-4	Heavy 4-5	Very Heavy >5

I am taking: Prenatal Vitamins | Iron Supplements | Folic Acid

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.

Date	How many weeks you were at delivery	Hours of labor	Type of Anesthesia Used	Vaginal, C/S, Forceps, Vacuum	Hospital and State	Sex of Baby	Weight	Any Complications/ Hospitalizations During Pregnancy/Medication

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?

YES	NO	Prenatal Care	YES	NO	Home Visiting Nurse
YES	NO	Childbirth Preparation Classes	YES	NO	Couples Counseling
YES	NO	Breastfeeding	YES	NO	Individual Counseling
YES	NO	Infant Care	YES	NO	Stress/Anger Management
YES	NO	Labor and Delivery Tour	YES	NO	Financial Planning
YES	NO	WIC	YES	NO	Single Parents Group
YES	NO	Sibling Classes	YES	NO	Domestic Violence Treatment

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

Ifyes: _____

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 JAW 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.

REPORT TITLE	OTSG APPROVED *(Date)*
TAMC Prenatal Genetic Screen*	*(20071025) 4NOV1987*

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? Yes _____ No _____
   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? Yes _____ No _____
   a. If yes, indicate the relationship of the affected person to you or to 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 thebaby'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? Yes _____ No _____
   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 or 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 OTHER EXAMINATION OR EVALUATION DIAGNOSTIC STUDIES TREATMENT	FLOW CHART OTHER *(specify)*

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)*
1. NAME OF PATIENT *(Last, First, Middle Initial)*	**2. ADDRESS OF PATIENT** *(Give specific directions)*
3. DATE OF BIRTH / **4. AGE** / **5. HOME PHONE**	
6. PATIENT SSN:	

7. NAME OF SPONSOR *(Last, First, Middle Initial)*		**8. SPONSOR'S GRADE AND SSN**	**9. BRANCH OF SERVICE**
10. ORGANIZATION	**11. WORK PHONE**	**12. MARITAL STATUS**	**13. FIRST TERM ENLISTMENT?** YES NO
14. SPONSORS LAST DEPOLYMENT: **PENDING DEPLOYMENT: Y / N**	**15. NUMBER OF PREGNANCIES: NUMBER OF CHILDREN: Total number and attach face sheet with ages** **CHILDREN WITH SPECIAL NEEDS: Y / N** **IF YES, SPECIFCY:**		**16. ESTIMATED DUE DATE:**

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
    IfYes, when? _____
16. Do you or your spouse have a history of mental illness, i.e. depression? No Yes

CENTERING PREGNANCY PROGRAM

Welcome to the TAMC 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.

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

808.433.4593

TAMC'S Centering Pregnancy Program

OB REG NURSES: PLEASE FORWARD THIS INFORMATION TO THE CENTERING COORDINATOR AT TAMC OB/GYN CLINIC

PLEASE PRINT LEGIBLY.

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 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: _____