

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MATERNAL INFANT HEALTH PROGRAM
PRENATAL PLAN OF CARE**

Beneficiary Name	Care Coordinator	Discipline
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PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Demographics and Health History Risk <input type="checkbox"/> Client needs information on resources available and how to access health care providers for:		
Prenatal Care/Nutrition <input type="checkbox"/> Client needs information on resources available and how to access prenatal care providers to assist her to get to her appointments. <input type="checkbox"/> Client needs information on prenatal nutrition due to:		
Smoking <input type="checkbox"/> Client needs information on effects of tobacco on her baby. <input type="checkbox"/> Client needs information on how to decrease tobacco use.	Client will have information to recognize risk of substances to self and fetus and will: <input type="checkbox"/> Have a smoke free environment <input type="checkbox"/> Quit smoking by (date): / / <input type="checkbox"/> Decrease cigarette use to (number): per day by (date) / / <input type="checkbox"/> Identify a support for smoking cessation	
Alcohol/Drug Use <input type="checkbox"/> Client needs information on effects of substances on her baby. <input type="checkbox"/> Client needs information on resources available to assist her to decrease or discontinue her substance use.		

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PRENATAL PLAN OF CARE

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Stress <input type="checkbox"/> Client needs information on how to deal with stress.	Client will verbalize her stress has decreased.	
Depression and Mental Health <input type="checkbox"/> Client needs information on perinatal depression.		
Social Support <input type="checkbox"/> Client needs assistance with finding a good support system.	Client will identify a support system and will describe who will support her during her pregnancy and after delivery of the baby.	
Abuse/Violence		
Basic Needs <input type="checkbox"/> Client needs information on (circle appropriate responses): housing; financial resources; food supply; transportation; Other:		

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PRENATAL PLAN OF CARE

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<p>Breastfeeding</p> <p><input type="checkbox"/> Client needs information on the benefits of breastfeeding.</p> <p><input type="checkbox"/> Client needs information on breastfeeding techniques and supportive community resources.</p>		
<p>Family Planning</p> <p><input type="checkbox"/> Client needs information on contraceptive options available.</p> <p><input type="checkbox"/> Client needs information on how to access reproductive health care after Medicaid coverage ends.</p>	<p>Client will verbalize future reproductive plans, including:</p> <p><input type="checkbox"/> Contraceptive Choice:</p> <p><input type="checkbox"/> Reproductive Health Care Provider:</p> <p><input type="checkbox"/> Method of Payment for Care:</p> <p><input type="checkbox"/> Spacing of Children</p>	
<p>Other</p>		
<p>Other</p>		
<p>Other</p>		

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PRENATAL PLAN OF CARE

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Other		
Other		
Other		

We, the undersigned, have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature Date SW Signature Date RD Signature Date
Care Plan Update

We, the undersigned, have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature Date SW Signature Date RD Signature Date