

# ***Tripler Army Medical Center***

***(TAMC)***

## ***Department of Obstetrics***

### ***OB Registration Intake Packet***

***(Virtual appointments only)***



In order to provide you the best care please **complete and returned** to the OB Registration Intake Nurse prior to receiving first appointment. It is important that you **complete these forms** prior to your scheduled Virtual OB Registration Intake appointment. If forms are not completed and returned to OB/GYN clinic prior to your scheduled

***Virtual OB Registration Intake Nurse Appointment*** , your appointment will be rescheduled.

**How to send your completed OB Registration forms to the TAMC -OB/GYN Clinic?**

- Log in to your MHS Genesis portal message.
- TO: enter "USA Tripler OB/GYN Messaging"
- Attach your completed OB Registration forms and send to clinic. Please keep a copy for review w/OB REG appt.
- You can also download your prenatal records/pap reports to your MHS Genesis portal.

**IMPORTANT:** This first virtual OB Registration appointment is a 60 minute intake only appointment with a nurse. **Please Note:** At your first OB intake appointment the nurse will complete your full pregnancy intake health history, order your prenatal labs, prenatal medication as needed and make first appointment with a provider you select. The intake nurse will be scheduling your first OB dating scan with a provider you select. This first OB appointment is 40-60 min.

**Please arrive to all OB/GYN appointments 10 -15 min early for parking and check in.**

***Tripler Army Medical Center (TAMC) is the main site for all your OB/GYN care.***

*This packet is available at all MTF located in Hawaii (TAMC, DDHC, KBOB, MKOB, Warrior Ohana, & Hickam 15th MG).*

*TAMC- women's health official website at: <https://tripler.tricare.mil/Health-Services/Womens-Health-Pregnancy>*

***Schofield Barracks OB Registration nurse team my utilize a different OB registration form/QRS code. TAMC OB/GYN clinic do not utilize these forms. Please only submit their form to nurse at DDHC only & always keep a copy to review with RN.***

Tripler Army Medical Center (TAMC)

and

Schofield Barracks (DDHC)

For scheduling/canceling all appointments

OB/GYN clinic appointments.

**Appointment Line: 808-433-2778, or 888-683-2778 Option 3, 3, then 1**

(Please listen to the prompts because numbers can change).

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 808-433-1863, or by calling the main line at 808-433-2778 option 3, 3 then 1, and asking for the Centering Coordinator.

Your first face to face OB appointment will be conducted with a Physician, Nurse Practitioner, or a Certified Nurse Midwife. This first appointment will be a scheduled forty (40-60) minute appointment.

Your OB Anatomy ultrasound will be done at 20-24 weeks at the Antepartum Diagnostic Center (ADC) - located on 6th floor mountain side.

## **How to contact a TAMC medical staff at OB/GYN for questions or concerns?**

**OB/GYN Advice Nurse:** If you have any questions or concerns options that can be utilized for advice call: **1-888-683-2778, Option 3, 2. Advice Nurse at 1-800-TRI-CARE, option 1, or <https://mhsnurseadvice.com/home>**

**The Same Day Evaluation Clinic (SDEC)** located at Tripler Army Medical Center on the 4th floor Mountainside(4H) in the OB/GYN clinic. **The Same Day Evaluation Clinic (SDEC)** hours of operation are:

**Monday thru Thursday 0800am - 1200pm**

**Friday 0800am - 1100am.**

The **SDEC** is available for the following problems:

**Pregnant women with urgent medical issues less than 20 Weeks Gestation only with;**

- Vaginal Bleeding with cramps
- Repeated nausea and vomiting for greater than 24 hours
- Vaginal Burning/Pain/Irritation
- Cramping/pain that will that does not go away or worsens

*Please Note: If you are pregnant and greater than 20 weeks gestation . You must report to Mountainside 6<sup>th</sup> Floor Labor and Delivery Triage (6F). **Do not go to TAMC ER or SDEC.***

### **When do I need to come to SDEC - urgent care?**

- 1. When you are pregnant and less than 20 Weeks Gestation**
- 2. Post Surgical problems**
- 3. Postpartum problems (up to 6-8 weeks after delivering infant)**

- Fever greater than 100.4 without Respiratory Symptoms
- Blood pressure checks
- Post-Surgical Infection/Pain
- Injections

**After Hours urgent care:** If you are **less than 20 weeks pregnant** go to the **Emergency Room at Tripler Army Medical Center - located on Mountainside. 808-433-3706.**

**Other reasons to go directly to the Emergency Department:**

- Broken bones/limbs or possible sprain
- Car Accident
- Emergencies
- Fever greater than 100.5F/38C
- Loss of consciousness/Syncope
- Altered Mental status/Seizures
- Gastrointestinal disturbances
- Chest pain
- Trouble breathing
- Upper Respiratory Infection symptoms: Runny nose, cough, congestion, sore throat.
- COVID symptoms
- Non obstetrical emergencies

**Go directly to Labor and Delivery at Tripler if you are greater than 20 weeks pregnant for:**

- Decreased or absent fetal movement after 28 weeks gestation
- Leakage of Vaginal Fluid/ Bag of Water have broken
- Fall
- Vaginal Bleeding
- More than 6 contractions in one hour if less than 36 weeks gestation
- Severe abdominal pain
- Minor car accidents (fenderbender)
- Severe headache with visual disturbances

**Labor and Delivery Triage:** Phone Number: **808-433-9900**

**MHS Genesis Patient Portal**

You must have access to your MHS Genesis Portal to communication with your providers, send messages, access virtual appointments, send forms and view your medical informations.

**MHS Service Help-desk Customer Service Portal** (see below how to access).

**\*\*\*\*\*PLEASE SIGN UP FOR MHS GENESIS PATIENT PORTAL\*\*\*\*\***

**• To sign up visit:**

- <https://patientportal.mhsgenesis.health.mil>
- Call for assist 800-600-9332 or DSN 312-838-3000
- <https://www.tricare.mil/GettingCare/VirtualHealth/SecurePatientPortal/SecureLogin/TechnicalHelp>

**To SCHEDULE/CANCEL an appointment, please call 808-433-2778, option 3, 3, then 1. Please listen to prompts for changes.**

Your virtual intake 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. You can also download your prenatal records to your MHS Genesis portal.

**IMPORTANT:** This first virtual OB Registration appointment is a 60 minute intake only appointment with a nurse. Please be aware, at this intake appointment the nurse will complete your full pregnancy intake, health history, order your prenatal labs & medication as needed and make first appointment with a provider you select. The intake nurse will be scheduling your first OB dating scan with a provider you select. ***Your first OB/GYN appointment with a provider will be 40 - 60 min.***

**Please arrive to all OB/GYN appointments 10 -15 min early for parking and check in.**

**For all virtual health appointments, please check you connects prior to appointment to make sure all computers/phones are working properly.**

***Any cancellations, rescheduling or issues with virtual connections please call 808-433-2778, option 3, 3, then 1. Please listen to prompts for changes.***

***OB-GYN available providers: (circle one preferred provider)***

***OB-GYN MD Provider/ Certified Nurse Midwife/ Nurse Practitioner/ Resident MD Providers/Centering Pregnancy Program.***

Your first OB/GYN appointment is scheduled on \_\_\_\_\_ at \_\_\_\_\_  
(date) (time)  
with \_\_\_\_\_ at Tripler Army Medical Center / Schofield Barracks/MKOB/KBOB.  
(Provider)

**\*\*If you are transferring in care (i.e. have received care for this pregnancy at another facility) please bring all your prenatal records with you, for you first face to face appointment.\*\***

***We look forward to meeting you and caring for your and your family!***

## Childcare Options

**\*\*\*Please see note below for TAMC children in OB/GYN clinic policy \*\*\*** Children are welcome at many of the appointments that you will attend during your prenatal care; however, we ask that you "***please 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 for more information.

[www.himwr.com/child-development-centers](http://www.himwr.com/child-development-centers) or [www.greatlifehawaii.com](http://www.greatlifehawaii.com)

- 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 808-839-1988 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 (888) 683-2778, opt 3, 3, 1 as soon as possible to cancel your appointment and to reschedule.***

### **\*\*\* TAMC Guidance for children in OB/GYN clinic appointment only\*\***

Note: This does not apply for ADC appointments or Centering appointments.

Children are allowed in exam room. ALL Children must be care for, held or attended to by another parent/support person. No child/children are allowed in OB/GYN clinic exam rooms appointments alone while that parent is the patient seen by provider. All Parent's/support person are allowed to wait with child/children in OB/GYN waiting area during patient scheduled appointment.

# OB Registration

Please fill this form out completely before your appointment with the OB Registration Nurse

<b>Your Last Name</b> <input style="width: 95%;" type="text"/>	<b>First Name</b> <input style="width: 95%;" type="text"/>	<b>Your DOD #</b> <input style="width: 95%;" type="text"/>
<b>Marital Status</b> _____	<b>Ethnicity</b> OTHER: _____	<b>Check one: (you are)</b> Dependent _____ Active Duty _____ (O-1, E-1, etc)
<b>Your Date of Birth</b> _____	<b>Primary Language</b> _____	<b>Religious Preference</b> _____
		<b>PCS/DEROS Date:</b> _____
		<b>Profile Completed *</b> Yes _____ No _____ <b>Branch - Army only*</b>

<b>Sponsor's:</b>		
Branch of Service: _____	Base/Post Stationed at: _____	PCS/DEROS Date: _____

<b>Spouse/FOB/SO</b>			
<b>Last Name</b> <input style="width: 95%;" type="text"/>	<b>First Name</b> <input style="width: 95%;" type="text"/>	<b>Date of Birth</b> _ / _ / _	<b>Circle one</b> Dependent _____ Active Duty _____ (O-1, E-1, etc)
<b>Father of Baby is</b> Aware of my pregnancy _____ Supportive of my pregnancy _____	<b>Father's Ethnicity:</b> _____		<b>Phone Number</b> <input style="width: 150px;" type="text"/>

<b>Address:</b>		<b>Hotel Currently?</b>	Yes	No
<input style="width: 95%;" type="text"/> <b>Street</b>		If yes, do not fill in address. Update when receive housing.		
<input style="width: 95%;" type="text"/> <b>City, State, Zip</b>				
<input style="width: 150px;" type="text"/> <b>Home Phone</b>	<input style="width: 150px;" type="text"/> <b>Work Phone</b>	<input style="width: 150px;" type="text"/> <b>Email</b>		

Please rank the following according to your daily use: **Are you exposed to any 2nd hand smoke/vaping?** \_\_\_\_\_

Smoking/Vape/:	Never	Recently Quit					
			Light	Moderate	Heavy	Very Heavy	
			< one pack	1-1.5 pack	1.5-2 packs	>2 packs	
Illicit Drug Used:			Light	Moderate	Heavy	Very Heavy	
			1-2 times/year	34	45	>5	
Alcoholic Beverages:			Light	Moderate	Heavy	Very Heavy	
			1-2 drinks/month	34	45	>5	
Caffeinated Beverages:			Light	Moderate	Heavy	Very Heavy	
			1-2 times/day	34	45	>5	

I am taking: Prenatal \_\_\_\_\_ Iron \_\_\_\_\_ Folic Acid \_\_\_\_\_ Own Prenatal vitamins \_\_\_\_\_ Place select preferred Military pharmacy for Rx. \_\_\_\_\_

Please list below, any other prescribed or OTC medications such as, vitamins, or herbal supplements you take.

How many hours of sleep do you get each night? \_\_\_\_\_ What is your exercise activity ? Fair / Good / Excellent \_\_\_\_\_

<b>**OB Registration Nurse</b>		<b>*****Do Not write in this</b>		<b>Nurse</b>		<b>*****Do Not Write in this</b>	
Vitals: BP	HR	RR	Temp	HT	WT	BMI	
1hr GTT	Profile	Consult	EPDS	GAD-7	MDQ	SIPT	
Labs	Genetic	MD	COB	Ref	Misc		

Please let us know if **your** past or present health history listed below.  
Please mark each area that applies to you and give a brief description. Please include date/year.

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

Do you have any chronic pain or concerns for the provider to be aware?

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

Any past Cardiac problems? \_\_\_\_\_

PULMONARY PROBLEMS / TUBERCULOSIS (TB)      Yes      No      If yes to TB ? \_\_\_\_\_

Do you own any cats?      YES      NO      Do you own any dogs? \_\_\_\_\_

Please check the box if **you** have 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 indicate what you are allergic to and type of reactions that occurs.

**Positive COVID 19 Test.** Please list all recent positive date(s). \_\_\_\_\_

**COVID vaccines/boosters.** How many COVID Vaccine/booster have you had currently?

Did you receive current Flu vaccine? Yes No. List date of current Flu vaccine. \_\_\_\_\_

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.

Have you had any blood transfusion? Yes No If yes, when(month/year)? \_\_\_\_\_

Did you have a reaction to blood transfusion? Yes No What type of reaction? \_\_\_\_\_

Will you accept blood transfusion if needed? Yes No \_\_\_\_\_

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 \*Transfer in patients >20wks only: Positive Fetal Movement ?

Are you experiencing any: NAUSEA VOMITING CRAMPING BLEEDING

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

What's the longest you breastfed your baby(s)? \_\_\_\_\_

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

Do you have any food cravings? NO YES. Types? \_\_\_\_\_

Do you avoid any foods? YES. They are \_\_\_\_\_

How would you describe your appetite? \_\_\_\_\_

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

<ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Childbirth Preparation Classes</li> <li>Breastfeeding</li> <li>Infant Care</li> <li>Labor and Delivery Tour</li> <li>WIC</li> <li>Sibling Classes</li> </ul>	<ul style="list-style-type: none"> <li>Home Visiting Nurse</li> <li>Couples Counseling</li> <li>Individual Counseling</li> <li>Stress/Anger Management</li> <li>Financial Planning</li> <li>Single Parents Group</li> <li>Domestic Violence Treatment</li> </ul>
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What is the best method of learning for you? Reading Verbal Electronic Video Demonstration

Employment Status: \_\_\_\_\_

School Status: \_\_\_\_\_

Highest education/grade that you have completed: \_\_\_\_\_

Job Activity Level \_\_\_\_\_

Work hazards \_\_\_\_\_

Do you work with any hazardous equipment within daily job? \_\_\_\_\_

Do you have any financial hardships that prevent you from getting medical care? \_\_\_\_\_

Do you have any cultural, language or religious preferences that would affect your care? \_\_\_\_\_

If yes, type: \_\_\_\_\_

During the past month, have you often been bothered by feeling down, depressed or hopeless? \_\_\_\_\_

During the past month, have you often been bothered by little interest or pleasure in doing things? \_\_\_\_\_

Do you have an Advance Medical Directive? \_\_\_\_\_ If no, are you interested in receiving information? \_\_\_\_\_

Have you ever been emotionally, physically or sexually abused? \_\_\_\_\_ In your past or present? \_\_\_\_\_

Do you feel safe in your current home and environment? \_\_\_\_\_

**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

**TAMC Prenatal Genetic Screen\***

OTSG APPROVED (Date)  
(20071025) 4NOV1987

1. Will you be 35 years or older when the baby is due? \_\_\_\_\_
2. Have you, the baby's father, or anyone in either of your families ever had the following disorders?
  - a. Down Syndrome \_\_\_\_\_
  - b. Other chromosomal abnormality \_\_\_\_\_
  - c. Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly \_\_\_\_\_
  - d. Hemophilia \_\_\_\_\_
  - e. Muscular dystrophy \_\_\_\_\_
  - f. Cystic fibrosis \_\_\_\_\_
  - 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? \_\_\_\_\_
5. Do you or the baby's father have any close relatives with intellectual disability? \_\_\_\_\_
  - 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? \_\_\_\_\_
  - 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? \_\_\_\_\_
  - 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? \_\_\_\_\_
  - 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? \_\_\_\_\_
  - 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  $\beta$ -thalassemia? \_\_\_\_\_
  - 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  $\alpha$ -thalassemia? \_\_\_\_\_
  - 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) \_\_\_\_\_  
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 OR EVALUATION	OTHER (specify)
	DIAGNOSTIC STUDIES	
	TREATMENT	

Patient's Name \_\_\_\_\_ DoD ID #: \_\_\_\_\_

## EDINBURGH PERINATAL DEPRESSION SCALE (EPDS)

### INSTRUCTIONS:

Please mark one box for each question that is the closest to how you have felt in the **PAST SEVEN DAYS**.

**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 so 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 well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

**7. I have been so unhappy that I have had 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

ATTENTION: If you have had ANY thoughts of harming yourself, please tell your Provider today.

Comments: \_\_\_\_\_

**TOTAL SCORE: \_\_\_/30**

# Mood Disorder Questionnaire [MDQ]

**(1) Has there ever been a period of time when you were not your usual self and...**

**Yes      No**

... Felt so good or hyper that you were not your normal self or so hyper that you got into trouble?

... You were so irritable that you shouted at people or started fights or arguments?

... You felt much more self-confident than usual?

... You got much less sleep than usual and found you didn't really miss it?

... You were much more talkative or spoke much faster than usual?

... Thoughts raced through your head or you couldn't slow your mind down?

... Easily distracted and had trouble concentrating or staying on track?

... You had much more energy than usual?

... You were much more active or did many more things than usual?

... Much more social or outgoing than usual; eg, calling friends in the middle of the night?

... You were much more interested in sex than usual?

... Unusual activities for you or that others might have thought were excessive, foolish, or risky?

... Spending money got you or your family into trouble

**Total MDQ Score** \_\_\_\_\_

**(2) If you checked YES to more than one of the above, have several of these ever happened during the same period of time?**

**Yes      NO**

**(3) How much of a problem did any of these cause you -- like being unable to work having family, money or legal troubles; or getting into arguments or fights?**

No problem

Minor problem

Moderate problem

Serious problem

**MDQ Screen Result**

Negative

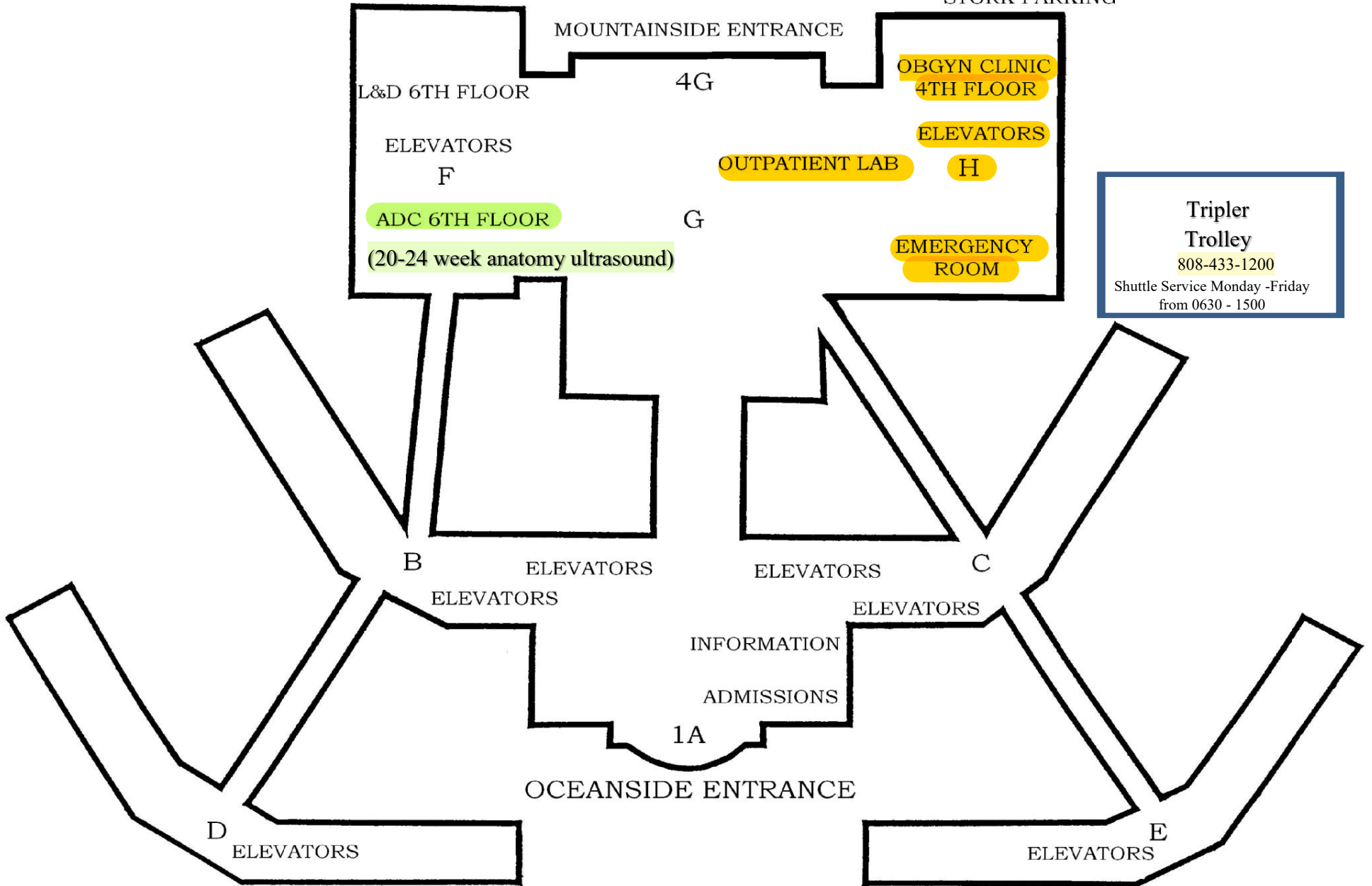
Positive

Positive Screen results from (7) or more 'Yes' responses to question (1) AND a 'Yes' response to question (2) AND a 'Moderate' or 'Serious' response to questions (3).

**A Positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.**

TRIPLER ARMY MEDICAL CENTER

STORK PARKING



**Popular Topics & Services**

-  Home Visits
-  Safe Sleep
-  Play Mornings
-  Prenatal Wellness
-  Behavior & Tantrums
-  Breastfeeding
-  Toilet Training
-  Nutrition
-  Development
-  Fatherhood
-  Infant Massage
-  Military Family Issues
-  Resources
-  Single Parenting
-  Information & Referrals



U. S.Army Garrison - Hawaii  
**Army Community Service**



# NEW PARENT SUPPORT PROGRAM

**Hours of operation**

**Monday-Friday**

**7:30A.M. - 4:30P.M.**

**310 Brannon Road**

**Building 690**

**Schofield Barracks, HI 96857**



**808-787-4227**

Important Telephone Numbers

Emergency	911
Domestic Violence Help	808-624-SAFE
Poison Control Help	800-222-1222
Military One Source	800-342-9647
Military Information	808-449-7110





**The New Parent Support Program (NPSP)**

**The New Parent Support Program is a professional team of nurses and social workers. We provide parenting support and education through home visits. Our staff is familiar with common parenting concerns and the unique challenges that military families face.**



**Who Is This For?**

The New Parent Support Program is a voluntary program developed to support new parents in ways that family and friends often do. Military families who are expecting or who have a child ages zero through three years old are invited to participate free of charge.



**What Can NPSP Do For Me?**

The New Parent Support Program provides support and reassurance throughout a season of life that usually comes with many questions and uncertainties. We tailor home visits to the needs of each family and offer the opportunity for parents to build on and learn new parenting skills.

The New Parent Support Program will connect you with reliable information from trusted sources and provide education from evidence-based resources. Our home visitors help strengthen families, increase parent-child bonds, and support parents in providing a nurturing and safe environment for their infants and toddlers.

**How Often Will Home Visitors Meet With Me and My Family?**

Home visitors will work with each family to establish a visiting schedule that meets the family's needs. Whether it be weekly, biweekly, or monthly, our home visitors will come to you to provide support and education in the convenience of your home.



**ENROLL NOW**

**808-787-4227**



**\*\*Complete these two forms- if interested in New Parent Support Program\*\***

**\*\*Bring these two pages with you to your first OB/GYN appointment. Give forms to clerk at main check-in desk.\*\***

(SEE PRIVACY ACT STATEMENT ON REVERSE)

**NEW PARENT SUPPORT PROGRAMS HAWAII – CASE REFERRAL  
VOLUNTARY PROGRAM**

<b>To:</b> <b>New Parent Support Programs Hawaii (NPSP Hawaii)</b> Army: <a href="mailto:usarmy.schofield.id-pacific.mbx.acs-npsp@army.mil">usarmy.schofield.id-pacific.mbx.acs-npsp@army.mil</a> OR Army: 808-787-4227 Marine Corps: 808-496-8803 Air Force, Coast Guard & Navy: 808-474-1999			<b>REFERRING PARTY</b> Name:  Location/Org:  Contact Phone#:		
<b>1. PARENT (1) NAME</b> (Last, First, MI) <input type="checkbox"/> Sponsor <input type="checkbox"/> Dependent <input type="checkbox"/> Civilian			<b>2. ADDRESS OF PARENT 1</b>		
<b>3. PARENT (1) GRADE/RANK ASSIGNED UNIT</b>		<b>4. MARITAL STATUS</b>			
<b>5. DATE OF BIRTH</b>	<b>6. DOD ID #</b>	<b>7. PHONE #</b>			
<b>8. EMAIL ADDRESS</b>					
<b>9. LAST DEPLOYMENT DATE:</b> <b>PENDING DEPLOYMENT DATE: Y / N</b>			<b>10. NUMBER OF PREGNANCIES:</b> <b>NUMBER OF CHILDREN:</b> <b>CHILDREN WITH SPECIAL NEEDS: Y / N</b> <b>IF YES, SPECIFY</b>		<b>11. ESTIMATED DUE DATE</b>
<b>12. PARENT (2) NAME</b> (Last, First, MI) <input type="checkbox"/> Sponsor <input type="checkbox"/> Dependent <input type="checkbox"/> Civilian			<b>13. ADDRESS OF PARENT 2</b>		
<b>14. PARENT (2) GRADE/RANK ASSIGNED UNIT</b>		<b>15. MARITAL STATUS</b>	<b>18. Phone #</b>		
<b>16. DATE OF BIRTH</b>	<b>17. DOD ID #</b>				
<b>19. EMAIL ADDRESS</b>					
<b>20. LAST DEPLOYMENT DATE:</b> <b>PENDING DEPLOYMENT DATE: Y / N</b>		<b>21. NUMBER OF PREGNANCIES:</b> <b>NUMBER OF CHILDREN:</b> <b>CHILDREN WITH SPECIAL NEEDS: Y / N</b> <b>IF YES, SPECIFY:</b>			<b>22. ESTIMATED DUE DATE</b>
<b>23. AUTHORIZATION FOR RELEASE OF INFORMATION</b>  I hereby authorize the release of information relevant to this referral to the New Parent Support Program for planning of prenatal health services and parenting support. I understand this is a VOLUNTARY PROGRAM and I consent to being contacted by a New Parent Support Home(NPSP) Visitor.					
<b>SIGNATURE OF PATIENT</b> (or person authorized to consent for patient)				<b>DATE</b>	



# TAMC's 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  
Mrs. Kurisu  
808.433.4593

# TAMC'S Centering Pregnancy Program

**\*\*Only complete this form if interested in 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: \_\_\_\_\_

# A Study About Active-Duty Women and Weight Loss After Pregnancy

Researchers at Tripler Army Medical Center want to learn more about factors that contribute to weight loss following pregnancy. Research is voluntary. The Principal Investigator of this study is Alan P. Gehrich, MD.



Scan to email study



## The Study May be a Good Fit for you if you are:

- Active Duty from any service
- Age 18-44 years old
- In your first pregnancy past 30 weeks gestation
- Have a physical fitness test on record prior to pregnancy
- Have not been on a profile limiting your ability to perform your standard physical fitness test prior to pregnancy and 1 year following pregnancy
- Will continue to serve on Active Duty for a minimum of 18 months after delivery
- Will remain on Oahu for a minimum of 12 months after delivery

## If you decide to volunteer for this study, you will:

- Be enrolled for 12 months of close supervision
- Collect 12 weeks of postpartum activity and dietary data study via a fitness tracker and mobile apps
- Closely watch your weight and assess your fitness over the course of 12 months
- Complete 6 study visits (2 of these visits may be conducted via the telephone) in the 12 months following your delivery to examine factors contributing to weight loss
- Commit approximately 20 hours (in the intervention group) or 10 hours (in the control group) of your time over the course of this 12-month study; the time will be mainly engaged in answering multiple questionnaires at points throughout the study and collecting sleep, exercise, and dietary data
- Be asked to submit your past and future physical fitness test results

There is NO cost to you. Those randomly selected to be in the intervention groups of the study are allowed to keep the fitness tracker. There is no guarantee that you will benefit from being in this research. However, others may benefit in the future from the information learned during this study. These benefits include better ways to help active-duty women following pregnancy to achieve their weight and physical fitness goals.

## Where will this research take place?

Visits will take place at Tripler Army Medical Center in the OB/GYN clinic or Schofield Clinics, depending on space and personnel availability. Telephonic visits can be done at any location.

If you think you are a candidate for the **Pregnancy, Active Duty and Weight Loss (PADaWL)** study and would like to volunteer, **please scan the QR code above.**



IRB NUMBER: 224014  
IRB APPROVAL DATE: 11/17/2023



## **Patients' Rights and Responsibilities**

All Medical Center and Dental Activity personnel will support these rights.

### ***Access to Care:***

Patients have the right to medical and dental care and treatment consistent with available resources and accepted standards. Patients have the responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.

### ***Participation in Care Planning:***

The patient has the right to make informed decisions regarding his/her care, to be told of her/her health status and to be a part of care planning and treatment. The patient has the right to decide if family members will participate in his/her care. The patient has the right to be involved in ethical questions that arise regarding his/her care and to refuse treatment, including withholding resuscitative services, foregoing or withdrawing life sustaining treatment to the extent permitted by law. The patient has the right to choose a decision maker in the event the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.

### ***Advance Healthcare Directive:***

The patient has the right to have an Advance Healthcare Directive which allows the patient to specify their health care wishes. The patient also has the right to name a person who would make health care decisions of the patient if he/she is unable to do so, to the extent permitted by law and hospital policy. The patient may also contact the Department of Social Work at 433- 6606 for assistance in preparing an Advanced Healthcare Directive

### ***Cultural and Religious Beliefs:***

The patient has the right to express spiritual beliefs and cultural practices, as long as these do not harm others or interfere with treatment. The hospital will provide pastoral counseling services for patients who request them.

### ***Communication Support:***

The patient has the right to effective communication or foreign and sign language interpreters. If any form of communication is withheld, including visitors, mail or telephone calls, the patient or his/her legal representative will be involved in the decision.

### ***Ethical Issues/Care at the End of Life:***

The patient has the right to be involved in ethical questions that arise in the course of his/her care. Decisions about care at the end of life will be handled with respect and sensitivity. If a patient or family would like to call an Ethics Committee member for help, please call 433-6661 during duty hours, or speak with the medical team. During non-duty hours, contact the Acting Officer of the Day (AOD) at 433-2646.

### ***Respect and Dignity:***

Patients and visitors, to include those with special needs, have the right to considerate and respectful care, with recognition of personal dignity. Patients should be considerate of the rights of other patients and medical and dental staff to include controlling noise and disturbances and following smoking policies. Staff will communicate with patients in a language or form understandable to the patient. Patients and visitors have the responsibility to inform the staff of any special needs or assistance that they require. Patients and staff must respect the property of others and of the facility.

### ***Privacy and Confidentiality:***

Patients have the right to privacy and confidentiality (as permitted by law and regulation) of all information concerning patient care or services. This includes privacy of written and oral communication and privacy during personal care. Case discussion, consultation, examination and treatment will be conducted so as to protect each patient's privacy. The staff will take reasonable steps to ensure patient security.

### ***Protective Services:***

The patient has the right to access protective services. The names, addresses and telephone numbers to protective services agencies will be provided upon request.

**Identity:**

Patients have the right to know at all times the name, professional status, and professional credentials of the health care personnel responsible for their care.

**Pain Management:**

Patients have the right to respectful and responsive care, which includes treatment of symptoms, appropriate assessment and management of pain.

**Refusal of Treatment:**

Patients have the right to refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of refusal.

**Research:**

Patients must be advised if the facility proposes to perform research associated with his or her care or treatment. Patients have the right to consent or refuse to participate in any proposed research studies affecting care and treatment, and to have those studies fully explained prior to consent. Any refusal to participate will not compromise a patient's access to other Hospital services.

**Informed Consent:**

Patients have the right to an explanation concerning diagnosis, treatment, procedures, and prognosis of illness in non-medical terms that the patient can understand prior to the start of any procedure and/or treatment requiring such consent, except in life threatening emergencies. In order to make knowledgeable decisions on treatment, patients and his/her family have the right to explanations regarding expected benefits, potential risk or complications prior to providing informed consent. The patient has the right to know of any medically significant alternatives for care or treatments. When it is not medically advisable to give such information to the patient, the information should be provided to appropriate family member(s) or, in their absence, another appropriate person. Patients are responsible for letting their healthcare provider know whether they understand the diagnosis, treatment plan, and expectations. Patients are responsible for participating with the health care provider in designing a medical treatment plan to include follow up care that they will be able to comply with. This includes keeping appointments on time and notifying the facility when appointments cannot be kept.

**Medical Records:**

Patients must ensure medical records are promptly returned to the medical facility for appropriate filing and maintenance when the patient transports records. All medical records documenting care provided are the property of the U.S. Government.

**Safety:**

Patients and families have a responsibility to be involved with the staff as partners in their medical care, with the goal of safe patient care. Patients have the right to care in a safe environment. The patient and family is responsible for:

- (a) Providing accurate and complete information about their health and condition, reporting unexpected changes in their condition and reporting any perceived risks in their care.
- (b) Asking questions in order to understand their condition and what they are expected to do.
- (c) Following the recommended care plan or course of treatment.
- (d) Expressing concerns about their ability to follow the proposed plan or treatment and understanding the consequences of treatment alternatives and of not following the proposed course.
- (e) Following MTF/DTF rules affecting patient care and conduct.

**Financial:**

Patients have the right and responsibility to seek information from the Health Benefits Advisors regarding health care expenses. Patients and families are responsible for prompt payment of any financial obligation agreed to with the medical facility.

**Hospital Policies and Procedures:**

Patients and visitors will be informed and need to follow the Medical Center's policies and procedures concerning patient care and conduct, to include policies regarding smoking, noise control and visitors. By following these policies, patients will help the Medical Center staff provide the best possible care for all beneficiaries.

**Requests for Assistance and Feedback:**

Patients have the right to make recommendations, ask questions, or file grievances. Questions and recommendations regarding quality of medical care, policies, services or other concerns may be addressed to the Customer Relations Office at 433-6336 or the Inspector General at 433-5628.