

Pediatric Associates of Lagrange
205 Calumet Center Road
Lagrange, GA 30241
(706) 885-1961

Lisa P. Allardice

Congratulations on your new bundle of joy. Oftentimes along with joy come feelings of sadness or being overwhelmed. Our office cares about your family and wants you to know we are here for you. It is recommended by the American Academy of Pediatrics to screen parents for postpartum depression. Our office wants to be supportive of efforts to address postpartum issues. We will ask you to complete this screening tool at newborn through your baby's first year visits. Depending on your score, we have resources that we can offer you if you have any signs of postpartum depression or just need to talk to someone about what you're feeling.

Postpartum depression is not the same as baby blues, which you may be familiar with. Postpartum depression lasts longer and is more serious than baby blues. Baby blues are feelings of sadness you may have in the first few days after having a baby. Baby blues can happen 2 to 3 days after you have your baby and can last up to 2 weeks. You may have trouble sleeping, be moody or cranky, and cry a lot. Postpartum depression (also called PPD) is a kind of depression that some women get after having a baby. It is strong feelings of sadness, anxiety (worry) and tiredness that last for a long time after giving birth. These feelings can make it hard for you to take care of yourself and your baby. PPD can happen any time after childbirth, but it often starts within 1 to 3 weeks of having a baby. Please remember PPD is not your fault and you didn't do anything to cause PPD. It doesn't make you a bad person or a bad mother. You are not alone. Please feel free to reach out to us since up to 1 in 7 women has PPD after giving birth, and it's the most common complication for women who have just had a baby. It's a medical condition that needs treatment to get better. If you have feelings that last longer than 2 weeks or if something doesn't seem right, call your healthcare provider.

With your permission we will share your scores with your OB/GYN. If needed, we will also give you information regarding resources and support networks.

- Permission to share with my OB/GYN or Primary Care Provider:

Name: _____ Phone: _____

- My contact information may be shared with referral sources:

Referral Source Name: _____ Phone: _____

Signature: _____ Date: _____

Print your name: _____

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
 - As much as I always could
 - Not quite so much now
 - Definitely not so much now
 - Not at all
2. I have looked forward with enjoyment to things
 - As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all
3. I have blamed myself unnecessarily when things went wrong
 - Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never
4. I have been anxious or worried for no good reason
 - No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often
5. I have felt scared or panicky for no very good reason
 - Yes, quite a lot
 - Yes, sometimes
 - No, not much
 - No, not at all
6. Things have been getting on top of me
 - Yes, most of the time I haven't been able to cope at all
 - Yes, sometimes I haven't been coping as well as usual
 - No, most of the time I have coped quite well
 - No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
 - Yes, most of the time
 - Yes, sometimes
 - Not very often
 - No, not at all
8. I have felt sad or miserable
 - Yes, most of the time
 - Yes, quite often
 - Not very often
 - No, not at all
9. I have been so unhappy that I have been crying
 - Yes, most of the time
 - Yes, quite often
 - Only occasionally
 - No, never
10. The thought of harming myself has occurred to me
 - Yes, quite often
 - Sometimes
 - Hardly ever
 - Never

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Plontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Patient Name: _____

Lead Risk Assessment Questionnaire

Circle Yes or No

*If Yes, please explain

- | | | | |
|--|-----|----|-------|
| 1. Does your child live in or often visit a house that may have been built before 1978? | Yes | No | _____ |
| 2. Does your child live in or often visit a house that is being remodeled or is having paint removed? | Yes | No | _____ |
| 3. Does your child live with or often visit another child that has an elevated blood lead level? | Yes | No | _____ |
| 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it? | Yes | No | _____ |
| 5. Does your child chew on or eat any non-food items like paint chips or dirt? | Yes | No | _____ |
| 6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead? | Yes | No | _____ |
| 7. Does your child receive medicines such as <i>greta</i> , <i>azarcon</i> , <i>kohl</i> or <i>pay-loo-ah</i> ? | Yes | No | _____ |

Risk Factors for Hearing Loss

- | | | |
|---|-----|----|
| 1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay | Yes | No |
| 2. Family history of permanent childhood hearing loss | Yes | No |
| 3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion | Yes | No |
| 4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis | Yes | No |
| 5. Craniofacial anomalies, especially involving the ear and temporal bone | Yes | No |
| 6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction | Yes | No |
| 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss | Yes | No |
| 8. Neurodegenerative disorders or sensory motor neuropathies | Yes | No |
| 9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis | Yes | No |
| 10. Head trauma | Yes | No |
| 11. Chemotherapy | Yes | No |
| 12. Recurrent or persistent ear infection for at least 3 months | Yes | No |

Parent Signature _____

Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

- | | | |
|---|---------------|------------|
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |

Patient Name: _____

Hepatitis B Vaccine:

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis B vaccine can prevent **hepatitis B**. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

- **Acute hepatitis B infection** is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements), and pain in the muscles, joints, and stomach.
- **Chronic hepatitis B infection** is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to liver damage (cirrhosis), liver cancer, and death. Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves.

Hepatitis B is spread when blood, semen, or other body fluid infected with the hepatitis B virus enters the body of a person who is not infected. People can become infected through:

- Birth (if a mother has hepatitis B, her baby can become infected)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Most people who are vaccinated with hepatitis B vaccine are immune for life.

2 Hepatitis B vaccine

Hepatitis B vaccine is usually given as 2, 3, or 4 shots.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age (sometimes it will take longer than 6 months to complete the series).

Children and adolescents younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is also recommended for certain **unvaccinated adults**:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, infection with hepatitis C, or diabetes
- Anyone who wants to be protected from hepatitis B

Hepatitis B vaccine may be given at the same time as other vaccines.



3

Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of hepatitis B vaccine**, or has any **severe, life-threatening allergies**.

In some cases, your health care provider may decide to postpone hepatitis B vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting hepatitis B vaccine.

Your health care provider can give you more information.

4

Risks of a vaccine reaction

- Soreness where the shot is given or fever can happen after hepatitis B vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5

What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6

The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7

How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
Hepatitis B Vaccine



Office use only

8/15/2019 | 42 U.S.C. § 300aa-26