

Screening for Post-Partum or Maternal Depression

Learning Collaborative

Initial Assessment

Practice Name: _____

1. What role(s) would you like to play in identifying and/or treating post-partum or maternal depression in your practice? (Please check all that apply.)

- I should observe mothers for signs of post-partum or maternal depression
- I should routinely ask mothers about symptoms of post-partum or maternal depression
- I should administer a questionnaire or screening tool to all mothers in my practice to identify those with post-partum or maternal depression
- I should prescribe medications for mothers who I diagnose with post-partum or maternal depression
- I should provide counseling for mothers who have post-partum or maternal depression
- I should refer mothers who have post-partum or maternal depression
- I have no role regarding post-partum or maternal depression

2. How comfortable are you in discussing post-partum or maternal depression with your patients or their mothers?

- Very comfortable Somewhat comfortable Not at all comfortable

3. If you HAVE identified a mother with post-partum or maternal depression, how did you do this? (Please check all that apply.)

- I noticed the mother's behavior and/or appearance
- The mother asked me directly about post-partum or maternal depression
- The mother told me she had post-partum or maternal depression
- I suspected depression based on the family dynamics or situation
- I used a questionnaire or screening tool to evaluate the mother
- Other – Please describe briefly: _____

4. If you use a questionnaire or screening tool to evaluate mothers for post-partum or maternal depression, what do you use?

(If possible, please fax or mail a copy of the questionnaire or screening tool when you return your responses to this form.)

5. When you refer a mother for maternal depression evaluation and/or treatment, where do you refer them? (Please check all that apply.)

- Community Mental Health Center (e.g., Valley Mental Health)
- OB/Gyn or other primary care physician
- Private psychiatrist or psychologist
- Private family therapist or social worker
- I would provide treatment to the mother in my office
- Other (please specify): _____

6. Finally, what do you hope to gain from your participation in this project? (You can use additional pages if you wish – just send them with the rest of the assessment.)

Confirmation of Team Members:

Physician or Mid-level Provider _____
(signature)

Nurse or Medical Assistant _____
(signature)

Office Manager or Administrator _____
(signature)

Post-Collaborative Office Visit:

We would like to set-up a brief appointment (15-20 minutes) to meet with your team one month after your participation in the Learning Session. We will be available at that time to assist you in completing your first chart audit.

Would you be available on _____ to meet? If so, please circle **YES** and we will plan on meeting you at your office at that time. If you are not available at that time, please propose a date and time that would work for you, and we will get back with you: _____.

**FAX back to: (801) 581-3899 by September 6, 2006
ATTENTION: Dana Patterson**