

EDINBURG POSTNATAL DEPRESSION SCALE¹ (EPDS)

Name: _____

Your Date of Birth: _____

Physician Name: _____

Baby's Date of Birth: _____

As to 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
 No, not very often
 No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

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

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. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.



PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider: _____	Phone: _____	Date: _____
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Child's Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ County: _____

Sex: Male Female Hispanic: No Yes Race: White Black Asian Am. Indian/Nat. Alaskan Other _____

US Born: Yes No If no, US Date of Arrival: ____/____/____ Country of Birth: _____

Parent/Guardian: _____ Phone: _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of country: _____
6. Is the child exposed to a person who: <ul style="list-style-type: none"> • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.

MEDICAL INFORMATION:

Primary Reason for Evaluation: Contact Investigation Targeted Testing Immigration Exam
 Incidental Abnormal CXR/CT Incidental Lab Result
 Other: _____

Symptomatic: No Yes If Yes, ONSET date: ____/____/____

Symptoms: Cough Hemoptysis Fever Night Sweats Weight Loss of ____ lbs.
 Other: _____

Tuberculin Skin Test (TST/Mantoux/PPD) Date Given: ____/____/____ Date Read: ____/____/____	Induration: ____ mm Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Interferon Gamma Release Assay (IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Chest X-ray (required with positive TST or IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal findings
<input type="checkbox"/> LTBI treatment (Rx and start date): Rx: _____ Date: ____/____/____ <input type="checkbox"/> Contraindications to INH or rifampin for LTBI	<input type="checkbox"/> Prior TB/LTBI treatment (Rx and duration): Rx: _____ mm <input type="checkbox"/> Offered but refused LTBI treatment

ADDITIONAL COMMENTS:

RECOMMENDATIONS:

Health Provider Signature: _____

Date Completed: ____/____/____