

Please Fax your Audit to NUMBER by DATE – Thank you!

## Screening for Maternal Depression Monthly Audit

Practice Name \_\_\_\_\_

Name and Phone Number of Person Completing Audit \_\_\_\_\_

Month \_\_\_\_\_

What tool(s) did you use this past month to screen for maternal depression? (Please check all that apply.)

- PRIME-MD/ 2 question screen (PHQ-2)
- PRIME-MD/Patient Health Questionnaire-9 (PHQ-9)
- Edinburgh Postnatal Depression Scale (EPDS)
- Family Psychosocial Screening (FPS)
- Beck Depression Inventory (BDI)
- Other- Please specify: \_\_\_\_\_
- None

Select 5 charts that meet the following criteria:

- Patient age newborn to 12 months
- Had a well child care visit in the past month

Screening			
Chart	Was a maternal depression screening tool completed as part of well-child check? (Y/N)	If yes, please list which tool(s) you used. (PHQ-2, PHQ-9, EPDS, FPS, BDI, Other)	Did the screening results indicate a need for additional evaluation or treatment? (Y/N)
1			
2			
3			
4			
5			

If any of the five moms above had a screening result that indicated a need for additional evaluation or treatment, please complete the following questions:

Referral			
Chart	Was the mother referred for further evaluation? (Y/N)	If yes, where was the mother referred? (Please describe briefly below.)	Was the mother treated or counseled in the office? (Y/N)
1			
2			
3			
4			
5			

Please tell us how you feel this project is going for your practice. Please rate yourself from 1 to 5:

1                      2                      3                      4                      5  
 (Not started yet) (Just started) (Getting there) (Doing well) (Doing great)

Would you like us to contact your practice for technical assistance?  Yes  No