EDINBURG POSTNATAL DEPRESSION SCALE[1] (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:

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 that 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 bee 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: _____

[1]Source: 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

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

IDPH
Illinois Department of Public Health

PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider:	Phone:	Date:

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?	❒ Yes ❒ 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?	❒ Yes ❒ 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?	❒ Yes ❒ 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?	❒ Yes ❒ 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?	❒ Yes ❒ No	If yes, name of country: _____
6. Is the child exposed to a person who: • 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?	❒ Yes ❒ No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	❒ Yes ❒ No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒ Yes ❒ 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:** ❒ Negative ❒ Positive
Interferon Gamma Release Assay (IGRA) **Date:** _____/_____/_____	**Impression:** ❒ Negative ❒ Positive ❒ Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date:** _____/_____/_____	**Impression:** ❒ Normal ❒ Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:_____ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: _____ _____mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

Health Provider Signature: _____ **Date Completed:** ____/____/____