**How to use this example guideline**

This document is an example to hospitals of a written guideline from which content can be borrowed and applied to individual hospital guideline templates. Not all information needs to be included in a guideline or the body of a guideline. Hospitals must still use their internal approval process for publishing practice documents.

**Screening for Perinatal Mood and Anxiety Disorders (PMAD)**

1. Verbal screening for depression, suicide risk, or PMAD
   1. Procedure
      1. It is best to screen patients:
         1. After they have been told that all patients are screened
         2. With their permission
         3. When clinically stable and outside of active labor
         4. Without others present who may influence the patient’s response
      2. The C-SSRS and the PHQ-2 are validated as verbal screening tools
      3. The EPDS is validated as a questionnaire for the patient to fill out
      4. Answers will be documented in the EHR
   2. Screening per phase of care:
      1. OB triage:
         1. RNs will verbally screen all patients for suicide risk using the C-SSRS validated screening tool, and document in the EHR.
         2. RNs will verbally screen all patients for depression using the PHQ-2 validated screening tool, and document in the EHR.
      2. Hospital stay
         1. RNs will verbally screen all patients for suicide risk using the C-SSRS validated screening tool within 8 hours of admission, and document in the EHR.
         2. RNs will verbally screen all patients for depression using the PHQ-2 validated screening tool within 8 hours of admission.
         3. RNs will screen all patients for PMAD during the postpartum period using the EPDS validated screening tool, and document results in the EHR.
      3. Exclusions:
         1. Patients being seen for a scheduled procedural visit (i.e., NST or IV iron infusion).
   3. Upon positive screen for depression, suicide risk, or PMAD
      1. If patient has a positive screen on C-SSRS, follow the hospital practice document *xxxx (insert name of suicide risk assessment and intervention practice document here)*.
      2. If patient scores 1 or higher on question 10 of EPDS, complete the C-SSRS and follow the hospital practice document *xxxx (insert name of suicide risk assessment and intervention practice document here)*.

*Considerations: Most hospitals are required to have a hospital-wide plan in place for the care of patients screening positive for suicide risk.*

* + 1. OB provider:
       1. Notify provider if EPDS screening result is > 8.
       2. Request an order for social work consult if EPDS screening result is > 8.
       3. Discuss planning an appointment to re-screen within 2 weeks if EPDS screening result is > 12.
    2. Social work:
       1. Order a social work consult if EPDS screening result is > 8, including reason for consult.
       2. All attempts should be made to see a social worker prior to discharge if the EPDS screening result is > 12, for further assessment and resources.

*Considerations: Not all hospitals have in-house social work support 24/7.*