

**HOME VISIT FOR POSTNATAL ASSESSMENT
 AND FOLLOW-UP CARE**

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. County of Residence		

Newborn's Name: _____
 Newborn's Birth Date: _____
 Weight: _____ Gestational Age: _____
 Outcome: discharged home in hospital died
 Patient's Medicaid No.: _____
 Educational Level: _____ Employed: Yes No
 Type of Work: _____
 Date of Return to Work: _____

Patient's Marital Status: S M Sep Div Widow CMHRP: Yes No

Telephone () _____ Relative/Contact Person: _____ Telephone () _____

Address: _____

Does patient speak English? Yes No Staff Bilingual — If no, who will interpret?

Instructions: Prenatal and Labor and Delivery history should be reviewed prior to appointment.

I. PRENATAL HISTORY	CODE	COMMENTS/TEACHING/HANDOUTS
A. Source of Prenatal Care		Please indicate provider/practice where prenatal care obtained; if no prenatal care, state this.
B. When Prenatal Care Began		____Weeks /Days Gestation
C. Drug Use: (Code as Y or N)		If yes to 1-5, please provide comment.
1. Tobacco (Cigarettes/Cigar/Cigarillos/ Chew/Snuff/Snus/Hookah/Strips/Sticks/Orbs)		
2. Electronic Nicotine Device/Vaping		
3. Alcohol		
4. Illegal Drugs		
5. Prescription/Over-the Counter Drugs Herbal Supplements/Remedies		
D. STI/HIV (Code as Y or N)		
E. GBS (Code as Y or N)		If yes, treated during delivery? (Y or N)
F. Hepatitis (Code as Y or N)		If yes, did infant receive HBIG at delivery? (Y or N)
G. Prenatal Complications (Code as Y or N)		If yes, please explain.
II. INTRAPARTUM	CODE	COMMENTS/TEACHING/HANDOUTS
A. Gravida/Parity — G__T__P__A__L__ (Include current delivery.) _____		
B. Place of Delivery	List site to right	
C. Type of Delivery	Check box to right	<input type="checkbox"/> Vaginal <input type="checkbox"/> C/S <input type="checkbox"/> Vaginal with Assistance (Forcep/Vac)
D. Problems During/After Delivery		If yes, please explain.
E. Received Immunization(s) as indicated post-delivery	Check appropriate boxes to the right	<input type="checkbox"/> Influenza <input type="checkbox"/> MMR <input type="checkbox"/> Tdap <input type="checkbox"/> Varicella <input type="checkbox"/> N/A

Name: _____ DOB: _____

III. INTERIM	CODE	COMMENTS/TEACHING/HANDOUTS
A. General Wellbeing (subjective)		
B. Physical Activities/Fatigue		
C. Emotional Status		
D. Depression Screening Tool Completed (PHQ9 or EPDS)		Screening Tool <input type="checkbox"/> PHQ-9 <input type="checkbox"/> EPDS Score: _____ Referral Made <input type="checkbox"/> Yes <input type="checkbox"/> No
IV. INFANT FEEDING	CODE	COMMENTS/TEACHING/HANDOUTS
A. Breast Feeding (Code Yes or No)		
B. Other infant feeding (Yes or No)		
C. Complications/Concerns		If yes, explain.
D. Support Systems/Resources Available		
V. HOME & SOCIAL ENVIRONMENT	CODE	COMMENTS/TEACHING/HANDOUTS
A. Type/Condition of Dwelling (Describe)		
B. Number in Household		Adults: _____ Children: _____
C. Water Supply/Plumbing		<input type="checkbox"/> Well <input type="checkbox"/> City Water <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor Plumbing
D. Basic Family Need for Clothing Met (Code Y or N)		
E. Working Stove and Refrigerator (Code Y or N)		
F. Electricity (Code Y or N)		
G. Environment/Safety Hazard		
H. Smoking—Home and/or Car (Code Y or N)		
I. Smoke/Carbon Monoxide Detectors (Code Y or N)		
J. Other		
VI. NUTRITION STATUS	CODE	COMMENTS/TEACHING/HANDOUTS
A. Appetite		
B. Vitamin/Mineral Supplement		
C. Adequate Food Supply		
D. Fluid Intake (64 fluid ounces daily) — preferably water		
VII. ELIMINATION	CODE	COMMENTS/TEACHING/HANDOUTS
A. Voiding/Bowel Function		
B. Hemorrhoids		
VIII. POSTPARTUM PHYSICAL ASSESSMENT	CODE	COMMENTS/TEACHING/HANDOUTS
This section may involve but does not require a hands-on physical exam. If assessed or observed by RN then describe findings. If findings are reported to the RN by the patient, then mark the box per patient report. Items coded with X must be explained.		
A. General Appearance (Code X or O; use SN as necessary)		
B. T/P/R/BP (Measure and document)		T - _____ P - _____ R - _____ BP - _____
C. Breast/Nipples (Code X or O)		Per Patient Report <input type="checkbox"/>
D. Abdomen — Incision(s) (Code X or O)		Per Patient Report <input type="checkbox"/>
E. Uterus (Code X or O)		Per Patient Report <input type="checkbox"/>
F. Lochia (Code X or O)		Per Patient Report <input type="checkbox"/>
G. Episiotomy/Perineum (Code X or O)		Per Patient Report <input type="checkbox"/>

Name: _____ DOB: _____

H. Legs (Code X or O)		Per Patient Report <input type="checkbox"/>
I. Other (Code X or O)		
IX. FAMILY RELATIONSHIPS	CODE	COMMENTS/TEACHING/HANDOUTS
A. Support Person	List relationship(s)	
B. Maternal-Infant Bonding	Observe and document	
C. Sexual Issues		
D. Interpersonal Violence		
X. CONTRACEPTION		COMMENTS/TEACHING/HANDOUTS
A. Current Method	Document to the right	
B. Planned Method	Document to the right	
C. Plans for Future Pregnancy		<input type="checkbox"/> No Plan for More Children
XI. REFERRAL (Code as Y, N or N/A)	CODE	COMMENTS/TEACHING/HANDOUTS
A. WIC		
B. Medicaid for FP Services		
C. Postpartum Exam/Family Planning		P.P. Exam - _____ F.P. - _____
D. Care Management for Children		
E. Breastfeeding Support		
F. Parenting Classes		
G. Transportation		
H. Newborn Assessment Completed		Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I. Primary Care Provider		
J. Other		
XII. COORDINATION OF SERVICES	CODE	Code this section using Y or N/A — If you check yes respond to the boxes to the right.
A. Collaboration with Pregnancy Care Manager		Prior to appointment <input type="checkbox"/> Post appointment <input type="checkbox"/> Date Completed _____
B. Collaboration with Care Management for Children		Prior to appointment <input type="checkbox"/> Post appointment <input type="checkbox"/> Date Completed _____
C. Other		

Signature: _____ Date of Appointment: _____

DATE	NOTES

Purpose: To record findings from the home visit assessment of postpartum patient.

Preparation: To be completed on every postpartum patient for whom a home visit assessment was done.