

COMPREHENSIVE PERINATAL SERVICES PROGRAM COMBINED POSTPARTUM ASSESSMENT

Name: _____ DOB: _____ Date: _____ I.D. No. _____

Health Plan: _____ Provider: _____ Delivery Facility: _____

Anthropometric:

1. Height _____ 2. Desirable Body Wt. _____ 3. Total Pregnancy Wt. Gain _____ 4. Wt. this visit _____
 5. Prepregnant wt. _____ 6. Postpartum Wt. Goal _____ 7. Weeks Postpartum this Visit _____

Biochemical:

Blood: Date Collected: _____

8. Hemoglobin: _____ (<10.5) 9. Hematocrit: _____ (<32) Other: _____

Urine: Date Collected: _____

10. Glucose: + - 11. Ketones: + - 12. Protein: + - Other: _____

13. Blood Pressure: _____ / _____ Comments: _____

Clinical - Outcome of Pregnancy:

14. Date of Birth: _____ 15. Gestational Age: _____ 16. Pregnancy/Delivery Complications: _____
 17. Birth Weight:(gms) _____ 18. Birth Length (cm): _____
 19. Current Weight: (gms) _____ 20. Current Length(cm): _____ Apgar Scores: 1 min: _____ 5 min: _____
 21. Type of Delivery: (circle) NSVD VBAC Vacuum Forceps C-Section (Primary or Repeat) (LTCS or Classical)

Maternal:

22. Have you had your postpartum check up? Yes Date: _____
 If No, when scheduled? _____
 23. Any health problems since delivery? Yes No
 If YES, please explain: _____

Infant:

24. Has infant had a newborn check-up?
 If No, when scheduled? _____
 If Yes, any Problems? _____
 25. Number of NICU Days: _____
 26. Infant exposure to: (circle all that apply)

Nutrition:

27. Maternal Dietary Assessment: For _____ Day(s)

Food Group	Servs./ Points	Suggested Change
Protein	_____	+ - _____
Milk Products	_____	+ - _____
Breads/Cereals/Grains	_____	+ - _____
Vit. C-rich fruit/veg	_____	+ - _____
Vit. A-rich fruit/veg	_____	+ - _____
Other fruit/veg	_____	+ - _____
Fats/Sweets	_____	+ - _____

Dietary Goals:
 Client agrees to: _____

Diet adequate as assessed: Yes No Excessive: Caffeine

REFERRALS: WIC Date Enrolled: _____
 Food Stamps Emergency Food AFDC

28. Infant

Method of Feeding: Breast Bottle Breast & Bottle # Wet diapers/day? _____
 Type of Formula: _____ With Iron? Yes No _____ oz.. _____ times/day

Psycho-Social

29. Do you feel comfortable in your relationship with your baby? Yes No _____
Any special concerns? _____
30. Are you experiencing post-partum blues? Yes No _____
31. Have your household members adjusted to your baby? Yes No _____
32. Has your relationship with the baby's father changed? Yes No _____
33. Do you have the resources to assist in maximizing the health of you and your baby? Yes No
If "No", indicate where needs exist: Housing Financial Food Family
Other: _____
34. Outstanding issues from Prenatal Assessment/Reassessment: _____

Health Education

35. If breast feeding:
Do you have enough milk? Yes No
Do you supplement with formula? Yes No
Does your baby take the breast easily? Yes No
Are your nipples cracked and/or sore? Yes No
Do you have any questions about breast feeding? Yes No
36. Do you have any questions about mixing or feeding formula? Yes No
37. Do you have any questions about your baby's health? Yes No
If "Yes", please explain: _____
38. Do you have any questions about your baby's safety? Yes No
If "Yes", please explain: _____
39. Are you using, or planning to use, any method of birth control? Yes No
If "Yes", which one? _____
If "No", would you like further information?

Plan:

Client Goals, Interventions and Timeline

Client agree to:

Referrals

Agency: _____ Date: _____ Agency: _____ Date: _____

Materials Given:

- | | | | | |
|--|---|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Infant Feeding | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Infant Safety | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Summary:

Date: _____ Interviewer: _____ Title _____ Minutes Spent: _____

Copy of Individualized Care Plan sent to Patient's PCP on: (date) _____ by: (name and title) _____