

**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 OBCM: 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 visit.

Check if Prenatal Record Available. If available, proceed to II

I. PRENATAL HISTORY	CODE	COMMENTS/TEACHING/HANDOUTS
A. Source of Prenatal Care		
B. When Prenatal Care Began		____ Weeks
C. Drug Use: (Code as Y or N)		
1. Tobacco		
2. Alcohol		
3. Illicit Drugs		
4. Prescription/Over-the Counter Drugs		
D. STD/HIV (Code as Y or N)		
E. GBS (Code as Y or N)		
F. Hepatitis (Code as Y or N)		
G. Prenatal Complications (Code as Y or N)		
II. INTRAPARTUM	CODE	COMMENTS/TEACHING/HANDOUTS
A. Gravida/Parity — G__P____		
B. Place of Delivery	List site and state to the right	
C. Type of Delivery	Check box to the right	<input type="checkbox"/> Vaginal <input type="checkbox"/> C/S <input type="checkbox"/> Vaginal with Assistance (Forcep/Vac)
D. Problems During/After Delivery		
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
III. INTERIM	CODE	COMMENTS/TEACHING/HANDOUTS
A. General Wellbeing (subjective)		
B. Physical Activities/Fatigue		
C. Emotional Status		
D. Depression Screening Tool Completed		

Name: _____ DOB: _____

IV. BREASTFEEDING	CODE	COMMENTS/TEACHING/HANDOUTS
A. Yes/No		
B. Complications/Concerns		
C. 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 of Food & Clothing		
E. 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. However, if findings are WNL per "patient report" mark the box next to each item.		
A. General Appearance (objective)		*WNL <input type="checkbox"/>
B. T/P/R/BP		T - _____ P - _____ R - _____ BP - _____
C. Pain Assessment Using VRNS (Patient's Reported #)		Patient's Current Level of Pain (0–10) _____
D. Breast/Nipples		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
E. Abdomen — Incision(s)		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
F. Uterus		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
G. Lochia		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
H. Episiotomy/Perineum		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
I. Legs/Homan Sign		*WNL <input type="checkbox"/> Per Patient Report <input type="checkbox"/>
J. Other		
IX. FAMILY RELATIONSHIPS	CODE	COMMENTS/TEACHING/HANDOUTS
A. Support Person	List name and relationship	
B. Maternal-Infant Bonding	Observe and document	
C. Sexual Issues		
D. Domestic Violence		

*WNL – Within Normal Limits

Name: _____ DOB: _____

X. CONTRACEPTION	CODE	COMMENTS/TEACHING/HANDOUTS
A. Current Method	Document to the right	
B. Planned Method	Document to the right	
C. Plans for Spacing Children		<input type="checkbox"/> ≤ 3 yrs apart <input type="checkbox"/> ≥ 5 yrs apart <input type="checkbox"/> ___ yrs apart
XI. REFERRAL (Code as Y, N or N/A)	CODE	COMMENTS/TEACHING/HANDOUTS
A. WIC		
B. Medicaid		
C. Postpartum Exam/Family Planning		P.P. Exam - _____ F.P. - _____
D. Care Coordination for Children (CC4C)		
E. Breastfeeding Support		
F. Parenting Classes		
G. Transportation		
H. <i>Be Smart</i> Medicaid for FP Services		
I. Newborn Assessment Completed		Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
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 OBCM (as indicated)		Prior to visit <input type="checkbox"/> Post visit <input type="checkbox"/> Date Completed _____
B. Collaboration with CC4C		Prior to visit <input type="checkbox"/> Post visit <input type="checkbox"/> Date Completed _____
C. Other		

Signature: _____ Date of Visit: _____

DATE	NOTES

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

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

Instructions: Complete according to guidelines provided in *Postpartum Home Visit Protocol*.

Disposition: Follow Schedule 5 of the *Records Disposition Schedule* published by the North Carolina Division of Archives and History.

Ordering: Additional forms may be ordered from: DHHS
 Women’s and Children’s Health Section
 1929 Mail Service Center
 Raleigh, NC 27699-1900
 Courier #56-20-11
 (919) 707-5700 FAX: (919) 870-4822