N.C. Department of Health and Human Services
Division of Public Health • Women's and Children's Health Section

# 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 ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White | | |
| 5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported | | |
| 6. Gender ☐ Female ☐ Male | | |
| 7. County of Residence | | |

Newborn's Name: ______

Newborn's Birth Date: ______

Weight: ______ Gestational Age: ______

Outcome: ☐ discharged home ☐ in hospital ☐ died

Mother's Medicaid No.: ______

Educational Level: ______ Employment: ______

| Mother's Marital Status: ☐ S ☐ M ☐ Sep ☐ Div ☐ Widow | MCC: ☐ Yes ☐ No | MOW: ☐ Yes ☐ No |
|---|---|---|
| Telephone ( ) ______ | Relative/Contact Person: | Telephone ( ) ______ |

| Address: | Directions to Home: |
|---|---|
| ______ | ______ |
| ______ | ______ |
| ______ | ______ |

Does mother 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:<br>1. Tobacco | | |
| 2. Alcohol | | |
| 3. Illicit Drugs | | |
| 4. Prescription/Over-the Counter Drugs | | |
| D. STD/HIV | | |
| E. GBS | | |
| F. Hepatitis | | |
| G. Prenatal Complications | | |
| **II. LABOR AND DELIVERY** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Gravida/Parity – G___P__ __ __ __ | | |
| B. Place of Delivery | | |
| C. Type of Delivery | | ☐ Vaginal ☐ C/S ☐ Vaginal with Assistance (Forcep/Vac) |
| D. Problems During/After Delivery | | |
| E. Received Immunization (s) as indicated | | ☐ N/A ☐ MMR ☐ Varicella ☐ Td ☐ Tdap |
| **III. INTERIM** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. General Wellbeing | | |
| B. Physical Activities/Fatigue | | |
| C. Emotional Status | | |
| D. Blues/Depression | | |
| **IV. BREASTFEEDING** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Yes/No | | |
| B. Complications/Concerns | | |
| C. Support Systems/Resources Available | | |



Codes: O = No Significant Problem; X = Significant Problem; Y = Yes; No = No; N = Notes; N/A = Not Applicable

Name: ______________________________ DOB: ____________

| V. HOME & SOCIAL ENVIRONMENT | CODE | COMMENTS/TEACHING/HANDOUTS |
|---|---|---|
| A. Type/Condition of Dwelling | | |
| B. Number in Household | | Adults: Children: |
| C. Cleanliness | | |
| D. Water Supply/Plumbing | | ☐ Well ☐ City Water ☐ Indoor ☐ Outdoor Plumbing |
| E. Stove and Refrigerator | | |
| F. Electricity | | |
| G. Environment/Safety Hazard | | |
| H. Smoking (Home and Car) | | |
| I. Smoke/Carbon Monoxide Detectors | | |
| J. Other | | |
| **VI. NUTRITION STATUS** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Appetite | | |
| B. Vitamin/Mineral Supplement | | |
| C. Adequate Food Supply | | |
| D. Fluid Intake | | |
| **VII. ELIMINATION** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Voiding/Bowel Function | | |
| B. Hemorrhoids | | |
| **VIII. POSTPARTUM PHYSICAL ASSESSMENT** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. General Appearance | | *WNL ☐ |
| B. T/P/R (if indicated) / B/P | | T - P - R - B/P - |
| C. Breast/Nipples | | *WNL ☐ |
| D. Abdomen (Incisions) | | *WNL ☐ |
| E. Uterus | | *WNL ☐ |
| F. Lochia | | *WNL ☐ |
| G. Episiotomy/Perineum | | *WNL ☐ |
| H. Legs/Homan Sign | | *WNL ☐ |
| I. Other | | |
| **IX. FAMILY RELATIONSHIPS** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Support Person | | |
| B. Maternal-Infant Bonding | | |
| C. Sexual Issues | | |
| D. Domestic Violence | | |
| **X. CONTRACEPTION** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. Current Method | | |
| B. Planned Method | | |
| C. Plans for Spacing Children | | ☐ ≤ 3 yrs apart ☐ ≥ 5 yrs apart ☐ ___ yrs apart |
| **XI. REFERRAL** | **CODE** | **COMMENTS/TEACHING/HANDOUTS** |
| A. WIC | | |
| B. Medicaid | | |
| C. Postpartum Exam/Family Planning | | P.P. Exam - F.P. - |
| D. Child Service Coordination (CSC) | | |
| E. Breastfeeding Support | | |

*WNL – Within Normal Limits



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Name: ______________________________ DOB: ______________

| | | |
|---|---|---|
| F. Parenting Classes | | |
| G. Transportation | | |
| H. Medicaid Waiver for FP Services | | |
| I. Newborn Assessment Completed | | Yes ☐ No ☐ N/A ☐ |
| J. Other | | |
| **XII. COORDINATION OF SERVICES** | **CODE** | |
| A. Collaboration with MCC | | Prior to visit ☐ Post visit ☐ |
| B. Collaboration with CSC | | Prior to visit ☐ Post visit ☐ |
| C. Other | | |

Signature: ______________________________ Date of Visit: ______________

| DATE | NOTES |
|---|---|
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**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 27699-1929
Courier #56-20-11
(919) 707-5700 FAX: (919) 870-4827



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