

Home Visit for Postnatal Assessment and Follow-Up Care

Health Department: _____

Date: _____

Reviewers: _____

Patient's Initials or Number

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1. Identifying Information

	1	2	3	4	5	6	7	8	9	10
Mother's name										
Marital status										
Education										
Employment										
Newborn's name										
Newborn's birth date										
Outcome*										
Record Compliant?										

Comments *enter date of miscarriage, abortion or stillbirth

2. Postpartum Home Visit (not a funding condition, but an encouraged practice)

	1	2	3	4	5	6	7	8	9	10
Within two weeks										

Comments

3. Prenatal History

	1	2	3	4	5	6	7	8	9	10
Prenatal record available										
Source of prenatal care										
Weeks gestation at 1st PNC visit										
Drug use: tobacco										
Drug use: alcohol										
Drug use: illicit drugs										
Drug use: rx and/or OTC										
STD/HIV										
GBS										
Hepatitis										
Prenatal complications										
Record Compliant?										

Comments

4. Labor and Delivery

	1	2	3	4	5	6	7	8	9	10
Gravida/Parity										
Date and place of delivery										
Type of delivery										
Problems during/after delivery										
Received Immunization(s) prn										
Record Compliant?										

Comments

5. Interim

	1	2	3	4	5	6	7	8	9	10
General well being										
Physical activities/fatigue										
Emotional status*										
"Blues"/depression										
Record Compliant?										

Comments

* Current emotional status related to:

1. Labor and delivery experiences
2. Feelings regarding motherhood
3. Mother's perception about how well her needs are being met
4. Support persons
5. Symptoms of depression (rejection/hostility to infant, decreased sleep, suicidal ideation, audio or visual hallucinations)
6. Fatigue that prevents mother from caring for baby or self

6. Breastfeeding

	1	2	3	4	5	6	7	8	9	10
Yes/No										
Complications/concerns/support/resources										
Record Compliant?										

Comments**7. Home Environment**

	1	2	3	4	5	6	7	8	9	10
Type of dwelling/condition*										
# adults & children in household										
Cleanliness										
Water supply/ Plumbing										
Stove/ Refrigerator										
Electricity										
Environment/safety hazard(s)										
Smoking (Home and Car)										
Smoke/Carbon Monoxide Detectors										
Record Compliant?										

Comments *Document type of dwelling and dwelling condition**8. Nutrition Status**

	1	2	3	4	5	6	7	8	9	10
Appetite										
Vitamin/mineral supplements										
Adequate food supply										
Fluid intake										
Record Compliant?										

Comments

9. Elimination

	1	2	3	4	5	6	7	8	9	10
Voiding/bowel function										
Hemorrhoids										
Record Compliant?										

Comments**10. Postpartum Physical Assessment**

	1	2	3	4	5	6	7	8	9	10
General appearance										
TPR (if indicated), B/P										
Breast/nipples										
Abdomen/incisions										
Uterus										
Lochia										
Episiotomy/perineum										
Legs/Homan Sign										
Other										
Record Compliant?										

Comments**11. Family Relationships**

	1	2	3	4	5	6	7	8	9	10
Support person										
Maternal-infant bonding										
Sexual issues										
Domestic Violence										
Record Compliant?										

Comments

12. Contraception

	1	2	3	4	5	6	7	8	9	10
Current method										
Planned method										
Plans for Spacing Children										
Record Compliant?										

Comments**13. Referrals**

	1	2	3	4	5	6	7	8	9	10
WIC										
Medicaid										
Postpartum/family planning										
Child Service Coordination										
Breastfeeding support										
Parenting classes										
Transportation										
Medicaid Waiver for FP Services										
Newborn Assessment Completed										
Other										
Record Compliant?										

Comments**14. Coordination of Services**

	1	2	3	4	5	6	7	8	9	10
Collaboration with MCC										
Collaboration with CSC										
Record Compliant?										

Comments