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)

Tobacco Alcohol Drugs

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	____	+ -	

Diet adequate as assessed: ❑ Yes ❑ No Excessive: ❑ Caffeine

Dietary Goals:

Client agrees to:

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:

❑ Birth Control	❑ Infant Feeding	❑ Infant Care	❑ Infant Safety
❑ _____	❑ _____	❑ _____	❑ _____
			❑ _____
			❑ _____

Summary:

Date:_____ Interviewer:_____ Title_____ Minutes Spent:____

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