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	____	+ -	

Dietary Goals:
Client agrees to:

REFERRALS: ☐ WIC Date Enrolled: _____

☐ Food Stamps ☐ Emergency Food ☐ AFDC

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

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)_____