

# 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	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Milk Products	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Breads/Cereals/Grains	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Vit. C-rich fruit/veg	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Vit. A-rich fruit/veg	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Other fruit/veg	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____
Fats/Sweets	_____	<input type="checkbox"/> + <input type="checkbox"/> - _____

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:

- |  |   |                                      |  |                                |
|--|---|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Infant Feeding | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Infant Safety | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____         | <input type="checkbox"/> _____          | <input type="checkbox"/> _____       | <input type="checkbox"/> _____         | <input type="checkbox"/> _____ |

## Summary:

Date: \_\_\_\_\_ Interviewer: \_\_\_\_\_ Title \_\_\_\_\_ Minutes Spent: \_\_\_\_\_

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