N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Women's Health Branch, Perinatal Health Unit

Healthy Beginnings Postpartum Assessment

Participant Information

Last Name **First Name** **MI**

Date of Birth Month Day Year

Race

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Biracial
- ☐ Other _____
- ☐ Unknown

Ethnic Origin ☐ Hispanic ☐ Non-Hispanic ☐ Not Identified

County of Residence

Home Address: ☐ Address change on Contact Update Log

_____

_____

_____

Phone: ☐ Phone # change on Contact Update Log

Home # _____

Cell # _____

Can participant receive text messages? ☐ Yes ☐ No _____ Part. Initials

Which is the best way to reach you? ☐ Home ☐ Cell

☐ Other (specify) _____

Emergency Contact:

Name _____

Relationship to Participant _____

Phone Number _____

Interpreter Services:

Do you need interpreter services? ☐ Yes ☐ No

What language do you prefer to speak/read?

_____

Does the participant have health insurance?

☐ Yes ☐ No

List Type of Insurance: _____

Does the baby have health insurance?

☐ Yes ☐ No

List Type of Insurance: _____

Client ID#

Date Form Initiated: Month Day Year

Staff Initials:

Contact Type: ☐ Phone ☐ Home Visit ☐ Office

☐ Newborn HV/Hospital Visit ☐ Other _____

Is participant enrolled in another program?

☐ Yes *(please specify)* _____ ☐ No

Participants **CANNOT** be enrolled in Healthy Beginnings if they are also enrolled in any of the following programs: Adolescent Parenting Program, Baby Love Plus, Nurse Family Partnership, or other home visiting program. Make sure to triage participants into the appropriate program to avoid duplication of services.

Medical/Dental Home:

Do you have a Primary Care Provider? ☐ Yes ☐ No
Name of Primary Care Provider

_____

Do you have a Dentist? ☐ Yes ☐ No
Name of Dentist

_____

Does your baby have a Primary Care Provider? ☐ Yes ☐ No
Name of Primary Care Provider

_____

What is participant's highest level of education completed?

- ☐ Some High School
- ☐ High School Diploma or GED
- ☐ Some College, no Degree
- ☐ Associate's Degree (2-year school)
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Other, Specify

_____

_____

Currently enrolled in school?

☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

If in school, list school schedule _____

_____

☐ No, but plans to enroll within the next year

Currently Employed?

☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

Place of employment _____

If employed, list work schedule _____

_____

Transportation:

Do you need assistance with transportation to get to medical/social service appointments? ☐ Yes ☐ No

Do you have and regularly use a car seat for your baby? ☐ Yes ☐ No

Father Involvement and Support:

Is the father of your baby involved in your life? ☐ Yes ☐ No

Who else do you depend on for support (i.e., partner, family, friends, faith community)?

_____

_____

Baby's Name(s): _____

Baby's Gender: ☐ Female ☐ Male

Baby's Due Date:

____ ____ _____
MM DD YYYY

Baby's Date of Birth:

____ ____ _____
MM DD YYYY

Baby's Birth Weight:

_____ _____
Pounds Ounces

Pre-pregnancy BMI:

Pre-pregnancy BMI _____

Height _____ Pre-pregnancy Weight _____
Inches Pounds

Postpartum BMI:

Do not obtain postpartum weight until 6 weeks after baby's birth.

Postpartum BMI _____

Height _____ Postpartum Weight _____
Inches Pounds

Postpartum Care:

Since your new baby was born, have you had a postpartum checkup for yourself? *(A postpartum checkup is the regular checkup a woman has with her OB/GYN usually 2–6 weeks after giving birth.)*

☐ Yes Date Checkup Occurred _____
(MM/DD/YYYY)

☐ No

Reproductive Life Planning:

1) Would you like to have any more children? ☐ Yes ☐ No

If yes, How many? _____When? _____

2) How important is it to you to prevent pregnancy (until then)?

_____

*Discuss birth control methods from most effective to least effective and what method(s) may fit her reproductive life plan. Recommend she discuss her plan and birth control methods with her provider.

*Women with short interpregnancy intervals (less than 18 months) are more likely to experience poor birth outcomes.

Birth Control Method:

What is the primary birth control method you or your husband/partner are using to keep from getting pregnant? (Check only one method)

☐ None

☐ Tubes tied or blocked (female sterilization, Essure®, Adiana®)

☐ Vasectomy (male sterilization)

☐ Birth control pill

☐ Condoms

☐ Injection (Depo-Provera®)

☐ Contraceptive implant (Nexplanon®)

☐ Contraceptive patch (OrthoEvra®, vaginal ring, NuvaRing®)

☐ IUD (including Mirena®, Skylar®, Kyleena®, Liletta®, ParaGard®)

☐ Natural family planning (including rhythm method)

☐ Withdrawal (pulling out)

☐ Not having sex (abstinence)

☐ Other (please specify) _____

Breastfeeding:

1) Are you currently breastfeeding or feeding pumped milk to your new baby?
   a) Yes (skip questions #2 & #3)
   b) No

2) Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?
   a) Yes
   b) No (enter 0 for question #3)

3) How many weeks did you breastfeed or pump milk to feed your baby?

_____ Number of Weeks

*Breastfeeding 0-3 days = 0 weeks, 4-7 days = 1 week

Safe Sleep: *Only ask these questions until baby turns 12 months old.*

1) In which one position do you most often lay your baby down to sleep now?
   a) On his or her side
   b) On his or her back
   c) On his or her stomach

2) How often does your new baby sleep in the same bed with you or anyone else?
   a) Always
   b) Often
   c) Sometimes
   d) Rarely
   e) Never

*The safest sleep position for a baby is on their back for the first 12 months, or until the baby can roll from stomach to back on their own. It is not safe for babies to sleep in the same bed with anyone.

Multivitamin/Folic Acid Consumption:

How often do you take a multivitamin now?

_____ Days a Week

* Recommended that ALL women of childbearing age get 400 micrograms of folic acid every day, even if they are not trying to become pregnant. It is important to take before becoming pregnant to help reduce the risk of birth defects of the brain and spine (neural tube defects).

Name _____ Date of Birth _____

Tobacco Use/Secondhand Smoke Exposure:

Conduct the 5As counseling intervention for quitting tobacco use.

1) "In the last three months of your pregnancy, how many cigarettes did you smoke on an average day?
   a) I didn't smoke then
   b) Less than 1 cigarette
   c) 1 to 5 cigarettes
   d) 6 to 10 cigarettes
   e) 11 to 20 cigarettes
   f) 21 or more cigarettes

2) How many cigarettes do you smoke on an average day now?
   a) Less than 1 cigarette
   b) 1 to 5 cigarettes
   c) 6 to 10 cigarettes
   d) 11 to 20 cigarettes
   e) 21 or more cigarettes

3) During the last three months of your pregnancy, on average, how often did you use other tobacco products or any electronic nicotine delivery system (such as vape pens, e-cigarettes, hookah pens)?
   a) I didn't then
   b) More than once a day
   c) Once a day
   d) 2-6 days a week
   e) 1 day a week or less

4) On average, how often do you use other tobacco products or any electronic nicotine delivery system now?
   a) I don't now
   b) More than once a day
   c) Once a day
   d) 2-6 days a week
   e) 1 day a week or less

5) Which of the following statements best describes the rules about smoking inside your home, even if no one who lives in your home is a smoker?
   a) No one is allowed to smoke anywhere inside my home
   b) Smoking is allowed in some rooms or at some times
   c) Smoking is permitted anywhere inside my home

*Explain the risks of secondhand smoke exposure and the benefits of eliminating secondhand smoke exposure.

Edinburgh Postnatal Depression Scale (EPDS):

1st Screening Date _____ _____ _____
MM DD YYYY

Referral made? ☐ Yes ☐ No

*Follow the Healthy Beginnings EPDS Policy and Procedures for administering, scoring, interpreting, and action/referral.

Alcohol and Substance Use:

State: "I ask all of my participants these questions because it is important to your health and the health of your baby."

Screening Questions:

1) Did any of your parents have a problem with alcohol or other drug use?
   ☐ Yes ☐ No ☐ Decline to answer

2) Do any of your friends have a problem with alcohol or other drug use?
   ☐ Yes ☐ No ☐ Decline to answer

3) Does your partner have a problem with alcohol or other drug use?
   ☐ Yes ☐ No ☐ Decline to answer

4) In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?
   ☐ Yes ☐ No ☐ Decline to answer

5) Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?
   ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

6) In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
   ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

Risk Assessment:

- **"No"** responses to all questions: Review benefits of abstinence.
- **"Yes"** response to Questions 1-3: Offer to provide information and or connect her with the Local Management Entity (LME) in your county.
  *Review the risk for potential alcohol and substance use and safety for the woman and her baby.
- **"Yes"** response to Question 4, and **"Sometimes or Frequently"** responses to Questions 5-6: Offer to connect her with the Alcohol Drug Council of NC **1-800-688-4232** or the LME in your county.
  *Inform her that alcohol and other drug use can impact parenting, especially with the challenges of a new infant.

Intimate Partner Violence (IPV):

State: "Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every participant about domestic violence."

Screening Questions:

1) Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No
2) Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No
3) Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No
4) Does your partner ever criticize you or embarrass you in front of others? ☐ Yes ☐ No
5) Does your partner put you down or keep you from contacting family or friends? ☐ Yes ☐ No

*For any **"Yes"** responses, offer to connect her with local domestic violence resources. If she needs emergency help, call **911**.

Legal Issues:

State: "So that I will have a better understanding of your current situation…"

1) Are criminal charges pending against you? ☐ Yes ☐ No
2) Are you currently on probation or parole? ☐ Yes ☐ No

Financial:

Currently, what are the primary sources of the participant's income/ financial resources? *(Check all that apply)*

☐ Food Stamps
☐ Participant's Employment
☐ Supplemental Security Income (SSI)
☐ WIC
☐ Work First
☐ Other _____

Does participant have financial support from the baby's father? ☐ Yes ☐ No

Can participant provide basic necessities for the baby? ☐ Yes ☐ No

Can participant provide basic necessities for herself? ☐ Yes ☐ No

Housing:

State: "Tell me about the safety and stability of your home or neighborhood."

1) Do you have a safe place to live? ☐ Yes ☐ No
2) Is it temporary or permanent? ☐ Temp ☐ Perm
3) Do you have any concerns about your child's safety at school or daycare? ☐ Yes ☐ No
4) Do you live in Public Housing? ☐ Yes ☐ No
5) Do you have?
   a) Electricity ☐ Yes ☐ No
   b) Indoor Plumbing ☐ Yes ☐ No
   c) Heat and Air Conditioning ☐ Yes ☐ No
   d) Working Smoke Alarms ☐ Yes ☐ No
6) Are there firearms (guns) in the home? ☐ Yes ☐ No

   If yes, where are they kept? _____

* Make sure that they store firearms (guns) separately from ammunition and that the firearms (guns) are locked up.

Coordinated Support Services

Document which support services were coordinated/referred during the postpartum assessment: (check all that apply)

☐ Breastfeeding/Lactation Consultant
☐ Child Care
☐ Domestic Violence
☐ Education/School Enrollment/GED
☐ Employment/Vocational Rehabilitation
☐ Family Planning Services
☐ Financial Assistance (baby items, clothing, furniture, rent, etc.)
☐ Housing Assistance
☐ Medical Care
☐ Mental Health Services
☐ Parenting Education
☐ Tobacco Cessation/QuitlineNC 1-800-QUIT-NOW
☐ Substance Use/Abuse Services
☐ Transportation
☐ WIC
☐ Other, please specify: _____

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Instructions for Healthy Beginnings Postpartum Assessment Form

Purpose: To collect information for newly enrolled postpartum program participants and pregnant enrollees after giving birth.

Instructions: Complete the entire assessment within 30 days of enrollment. File the assessment in program participant's record.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the North Carolina Office of Archives and History, Division of Historical Records.

_____ _____

Staff Signature and Date Staff Printed Name