1. Last Name	First Name	MI

2. Patient Number									

3. Date of Birth (MM/DD/YYYY)	Month	Day	Year

4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported

6. County of Residence

N.C. Department of Health and Human Services
Division of Public Health • Women's and Children's Health Section

HOME VISIT FOR POSTNATAL ASSESSMENT AND FOLLOW-UP CARE

Newborn's Name: _____

Newborn's Birth Date: _____

Weight: _____ Gestational Age: _____

Outcome: ☐ discharged home ☐ in hospital ☐ died

Patient's Medicaid No.: _____

Educational Level:_____ Employed: ☐ Yes ☐ No

Type of Work: _____

Date of Return to Work: _____

Patient's Marital Status: ☐ S ☐ M ☐ Sep ☐ Div ☐ Widow | OBCM: ☐ Yes ☐ No

Telephone (___) _____ | Relative/Contact Person: | Telephone (___) _____

Address:

Does patient speak English? ☐ Yes ☐ No ☐ Staff Bilingual — If no, who will interpret?

Instructions: Prenatal and Labor and Delivery history should be reviewed prior to appointment.

I. PRENATAL HISTORY	CODE	COMMENTS/TEACHING/HANDOUTS
A. Source of Prenatal Care		Please indicate provider/practice where prenatal care obtained; if no prenatal care, state this.
B. When Prenatal Care Began		___ Weeks /Days Gestation
C. Drug Use: (Code as Y or N)		If yes to 1-5, please provide comment.
1. Tobacco (Cigarettes/Cigar/Cigarillos/ Chew/Snuff/Snus/Hookah/Strips/Sticks/Orbs)		
2. Electronic Nicotine Device/Vaping		
3. Alcohol		
4. Illegal Drugs		
5. Prescription/Over-the Counter Drugs Herbal Supplements/Remedies		
D. STI/HIV (Code as Y or N)		
E. GBS (Code as Y or N)		If yes, treated during delivery? (Y or N)
F. Hepatitis (Code as Y or N)		If yes, did infant receive HBIG at delivery? (Y or N)
G. Prenatal Complications (Code as Y or N)		If yes, please explain.
II. INTRAPARTUM	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Gravida/Parity — G___T__ P__A__ L__ (Include current delivery.) _____		
B. Place of Delivery	List site to right	
C. Type of Delivery	Check box to right	☐ Vaginal ☐ C/S ☐ Vaginal with Assistance (Forcep/Vac)
D. Problems During/After Delivery		If yes, please explain.
E. Received Immunization(s) as indicated post-delivery	Check appropriate boxes to the right	☐ Influenza ☐ MMR ☐ Tdap ☐ Varicella ☐ N/A

Codes: O = No Significant Problem; X = Significant Problem; Y = Yes; N = No; SN = See Notes; N/A = Not Applicable

Name: _____ DOB: _____

III. INTERIM	CODE	COMMENTS/TEACHING/HANDOUTS
A. General Wellbeing (subjective)		
B. Physical Activities/Fatigue		
C. Emotional Status		
D. Depression Screening Tool Completed (PHQ9 or EPDS)		Screening Tool ☐ PHQ-9 ☐ EPDS Score: _____ Referral Made ☐ Yes ☐ No
IV. INFANT FEEDING	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Breast Feeding (Code Yes or No)		
B. Other infant feeding (Yes or No)		
C. Complications/Concerns		If yes, explain.
D. Support Systems/Resources Available		
V. HOME & SOCIAL ENVIRONMENT	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Type/Condition of Dwelling (Describe)		
B. Number in Household		Adults: Children:
C. Water Supply/Plumbing		☐ Well ☐ City Water ☐ Indoor ☐ Outdoor Plumbing
D. Basic Family Need for Clothing Met (Code Y or N)		
E. Working Stove and Refrigerator (Code Y or N)		
F. Electricity (Code Y or N)		
G. Environment/Safety Hazard		
H. Smoking—Home and/or Car (Code Y or N)		
I. Smoke/Carbon Monoxide Detectors (Code Y or N)		
J. Other		
VI. NUTRITION STATUS	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Appetite		
B. Vitamin/Mineral Supplement		
C. Adequate Food Supply		
D. Fluid Intake (64 fluid ounces daily) — preferably water		
VII. ELIMINATION	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Voiding/Bowel Function		
B. Hemorrhoids		
VIII. POSTPARTUM PHYSICAL ASSESSMENT	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
This section may involve but does not require a hands-on physical exam. If assessed or observed by RN then describe findings. If findings are reported to the RN by the patient, then mark the box per patient report. Items coded with X must be explained.		
A. General Appearance (Code X or O; use SN as necessary)		
B. T/P/R/BP (Measure and document)		T - P - R - BP -
C. Breast/Nipples (Code X or O)		Per Patient Report ☐
D. Abdomen — Incision(s) (Code X or O)		Per Patient Report ☐
E. Uterus (Code X or O)		Per Patient Report ☐
F. Lochia (Code X or O)		Per Patient Report ☐
G. Episiotomy/Perineum (Code X or O)		Per Patient Report ☐

Name: _____ DOB: _____

H. Legs (Code X or O)		Per Patient Report ☐
I. Other (Code X or O)		
IX. FAMILY RELATIONSHIPS	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. Support Person	List relationship(s)	
B. Maternal-Infant Bonding	Observe and document	
C. Sexual Issues		
D. Interpersonal Violence		
X. CONTRACEPTION		**COMMENTS/TEACHING/HANDOUTS**
A. Current Method	Document to the right	
B. Planned Method	Document to the right	
C. Plans for Spacing Children		☐ No Plan for More Children
XI. REFERRAL (Code as Y, N or N/A)	**CODE**	**COMMENTS/TEACHING/HANDOUTS**
A. WIC		
B. Medicaid ***BeSmart*** for FP Services		
C. Postpartum Exam/Family Planning		P.P. Exam - F.P. -
D. Care Management for Children		
E. Breastfeeding Support		
F. Parenting Classes		
G. Transportation		
H. Newborn Assessment Completed		Yes ☐ No ☐ N/A ☐
I. Other		
XII. COORDINATION OF SERVICES	**CODE**	**Code this section using Y or N/A — If you check yes respond to the boxes to the right.**
A. Collaboration with Pregnancy Care Manager		Prior to appointment ☐ Post appointment ☐ Date Completed _____
B. Collaboration with Care Management for Children		Prior to appointment ☐ Post appointment ☐ Date Completed _____
C. Other		

Signature: _____ Date of Appointment: _____

DATE	NOTES

Purpose: To record findings from the home visit assessment of postpartum patient.

Preparation: To be completed on every postpartum patient for whom a home visit assessment was done.