

**N.C. Department of Health and Human Services  
Division of Public Health  
Women, Infant, and Community Wellness Section**

## Home Visit for Postnatal Assessment/Follow-Up Care Audit Tool

Local Health Department: \_\_\_\_\_ Date \_\_\_\_\_

Patient Record Auditors — Name and Title: \_\_\_\_\_ County \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Patient Records Audit

No.	Patient Generic Identifier	Comments
1		
2		
3		
4		
5		

### Postpartum Home Visit

(not a funding condition, but an encouraged practice)

	1	2	3	4	5
A. Visit was done within two-three weeks from discharge					

### I. Prenatal History

	1	2	3	4	5
A. Prenatal Care					
B. When Prenatal Care Began (weeks/days gestation at initiation of prenatal care)					
C. Substance Use					
D. STI/HIV					
E. GBS					
F. Hepatitis					
G. Prenatal complications					

**Comments:**

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## II. Intrapartum

	1	2	3	4	5
A. Gravida/Parity (GTPAL)					
B. Place of Delivery					
C. Type of Delivery					
D. Problems During/After Delivery					
E. Received Immunization(s) as indicated post/delivery					

Comments:

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## III. Interim

	1	2	3	4	5
A. General Wellbeing (subjective)					
B. Physical Activities/Fatigue					
C. Emotional Status					
D. Depression Screening Tool Completed, Scored, and Referral if indicated (PHQ9 or EDPS)					

Comments:

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## IV. Infant Feeding

	1	2	3	4	5
A. Breastfeeding					
B. Other Infant Feeding					
C. Complications/Concerns					
D. Support Systems/Resources Available					

Comments:

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## V. Home & Social Environment

	1	2	3	4	5
A. Type/Condition of Dwelling (described)					
B. Number in Household (# of adults, # of children)					
C. Water Supply/Plumbing					
D. Basic Family Need of Clothing Met					
E. Working Stove and Refrigerator					
F. Electricity					
G. Environment/Safety Hazard					
H. Smoking—Home and/or Car					
I. Smoke/Carbon Monoxide Detectors					

Comments:

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## VI. Nutrition Status

	1	2	3	4	5
A. Appetite					
B. Vitamin/Mineral Supplement					
C. Adequate Food Supply					
D. Fluid Intake (64 fluid ounces daily)					

Comments:

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## VII. Elimination

	1	2	3	4	5
A. Voiding/Bowel Function					
B. Hemorrhoids					

Comments:

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## VIII. Postpartum Physical Assessment

	1	2	3	4	5
A. General Appearance					
B. T/P/R/BP (documentation of each)					
C. Breast/Nipples					
D. Abdomen—Incision(s)					
E. Uterus					
F. Lochia					
G. Episiotomy/Perineum					
H. Legs					

Comments:

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## IX. Family Relationships

	1	2	3	4	5
A. Support Person					
B. Maternal-Infant Bonding					
C. Sexual Issues					
D. Interpersonal Violence					

Comments:

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## X. Contraception

	1	2	3	4	5
A. Current Method					
B. Planned Method					
C. Plans for future pregnancy					

Comments:

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## XI. Referrals

	1	2	3	4	5
A. WIC					
B. Medicaid for FP Services					
C. Postpartum Exam/Family Planning					
D. Care Management for Children					
E. Breastfeeding Support					
F. Parenting Classes					
G. Transportation					
H. Newborn Assessment Completed					
I. Primary Care Provider					

Comments:

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## XII. Coordination of Services

	1	2	3	4	5
A. Collaboration Pregnancy Care Manager					
B. Collaboration with Care Management for Children					

Comments:

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