

Home Visit Postpartum/Infant Assessment Steps Ahead Maternity Care Program

Date: _____ Referral Source: _____ Referral Reason: _____

Mother's Information

Mother's Name:	Prenatal Care Provider:	Phone #:	
Address:	City:	State:	Zip:
Race:	Medicaid #:	Mother's Date of Birth:	

Infant's Information

Infant's Name:	Pediatric Provider:		
Infants Date of Birth	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Chart #	

Postpartum Assessment			Infant Assessment		
<p><u>Medical History</u></p> <p>Place of Delivery:</p> <p>Type of Delivery:</p> <p>PARA:</p> <p>Birth Control Method:</p> <p>Allergies:</p> <p>Complications:</p>	<p><u>Medications</u></p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p>	<p><u>Medical HX</u></p> <p>Birth Weight:</p> <p>Medications:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>Infant Complications:</p>	<p><u>Feeding</u></p> <p>Breastfeeding: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Formula Type:</p> <p>Amount:</p> <p>Tolerates Feedings: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>	<p><u>Elimination</u></p> <p>Wet Diapers - # per day:</p> <p>Stools - # per day:</p> <p>Consistency:</p> <p>Color:</p>	
<p><u>Vital Signs</u></p> <p>B/P:</p> <p>Temp:</p> <p>Pulse: bpm</p> <p>Resp.: bpm</p> <p>Repeat B/P:</p>	<p><u>Breasts</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Full/Engorged</p> <p><input type="checkbox"/> Cracked Nipples</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Other:</p>	<p><u>Abdomen</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Distention</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Incision</p> <p><input type="checkbox"/> Drainage</p>	<p><u>Measurements</u></p> <p>Temp:</p> <p>Pulse: bpm</p> <p>Resp.: bpm</p> <p>Weight:</p> <p>HC:</p>	<p><u>Neuromuscular</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Lethargic</p> <p><input type="checkbox"/> Hyper/Hypotonic</p> <p><input type="checkbox"/> Other:</p>	<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Tachycardia/Bradycardia</p> <p><input type="checkbox"/> Murmur</p> <p><input type="checkbox"/> Other:</p>
<p><u>Lochia</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Foul Odor</p> <p><input type="checkbox"/> Excessive Amount</p> <p><input type="checkbox"/> Bright Red</p> <p><input type="checkbox"/> Passing Clots</p> <p><input type="checkbox"/> Other:</p>	<p><u>Bladder</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Distention</p> <p><input type="checkbox"/> Frequency</p> <p><input type="checkbox"/> Urgency</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Hematuria</p> <p><input type="checkbox"/> Other:</p>	<p><u>Bowels</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Other:</p>	<p><u>Respiratory</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Rales/Rhonchi/Wheezing</p> <p><input type="checkbox"/> Tachypnea</p> <p><input type="checkbox"/> Other:</p>	<p><u>Head</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Fontanels Depressed/Bulging</p> <p><input type="checkbox"/> Eye Discoloration/Drainage</p> <p><input type="checkbox"/> Nasal Drainage</p> <p><input type="checkbox"/> Thrush</p> <p><input type="checkbox"/> Other:</p>	<p><u>Skin</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Birthmark/Mongolian Spots</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Other:</p>
<p><u>Extremities</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> Horman's Sign</p> <p><input type="checkbox"/> Edema</p>	<p><u>Emotional Status</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Tearful</p> <p><input type="checkbox"/> Moody</p> <p><input type="checkbox"/> Anxious</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Flat Affect</p> <p><input type="checkbox"/> Other:</p>	<p><u>Activity Level</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Fatigue/Exhaustion</p> <p><input type="checkbox"/> Sleep Disturbance</p> <p><input type="checkbox"/> Other:</p>	<p><u>Trunk</u></p> <p><input type="checkbox"/> No Problem Identified</p> <p><input type="checkbox"/> Abdominal Distention</p> <p><input type="checkbox"/> Abnormal Genital Appearance</p> <p><input type="checkbox"/> Other:</p>		<p><u>Extremities</u></p> <p><input type="checkbox"/> No Problems Identified</p> <p><input type="checkbox"/> Asymmetrical Appearance</p> <p><input type="checkbox"/> Asymmetrical Movement</p> <p><input type="checkbox"/> Hip Click R L</p> <p><input type="checkbox"/> Extra Digit</p> <p><input type="checkbox"/> Other:</p>
			<p><u>Umbilical Cord</u></p> <p><input type="checkbox"/> Drying <input type="checkbox"/> Moist <input type="checkbox"/> Odor</p> <p><input type="checkbox"/> Cord Off <input type="checkbox"/> Cord Care Done</p> <p><input type="checkbox"/> Other:</p>		<p><u>Circumcision</u></p> <p><input type="checkbox"/> N/A <input type="checkbox"/> Healing <input type="checkbox"/> Other:</p>

