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|  | | | | | | | | In-Home Postpartum Nursing Assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mom’s Name: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | CPID ID# | | | | | | |  | | | |
| Baby’s Name: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Baby’s DOB: | | | | | | |  | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Doctor: |  | | | | | | | | | | Phone: | | | | | | | | | | |  | | | | | | | Baby’s Gender: | | | | | | | | M  F | | | | |
| **Postpartum Visit Check** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Delivery: | | | | | Routine C/S  Emergency C/S Spontaneous Vaginal Delivery  Induced Vaginal Delivery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies: | | | | | None | | | | | | | | | | | | | | | | | | | | | | | Yes – what allergies? | | | | | | | | |  | | | | |
| Medications: | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | Dose | | | | | | | | | | | | | | | | Route | | | | | | | | | | | Frequency | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| **Clinical Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Normal | | | | | | | Abnormal | | | | | | | | Comments  (All abnormal require a comment) | | | | | | | | | | | | | | | | | | | | | |
| Nutrition | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Sleep/rest | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Neuro | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Vision | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Mental Health | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Elimination | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Perineum | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Lochia | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Pain | | | | | 1 2 3 4 5 6 7 8 9 10 | | | | | | | | | | | | | | | | | | | | | | | Location: | | | | | | | | | | | | | |
| Did you smoke in the last 3 months of your pregnancy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | |
| Breastfeeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you currently breastfeeding? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | |
| Length of feedings: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Frequency of feedings: | | | | | | | | | | | | | |
| Do you supplement with (sometimes use) formula? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | |
| Does your baby take your breast easily? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | |
| Are your nipples cracked and/or pain/sore? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | |
| Safe Spacing Plan | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Are you using, or planning to use, birth control? If so, what type? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| Psycho-Social Assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | |
| Do you feel comfortable in your relationship with your baby? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| Have your household members adjusted to your baby? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| Is the baby’s father supportive and/or involved with the baby? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| History of depression? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| History of baby blues? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| Support system for when you feel overwhelmed? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | Comment: | | | | | | | |
| Who do you call? | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| How does your partner feel about the baby?  (Check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | Happy Angry  Refused to be involved Not Sure | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Newborn Assessment:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mom’s Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Molina ID #: | | | | | | |  | | | | | | |
| Baby’s Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Baby’s DOB: | | | | | | |  | | | | | | |
| Gestational Age: | | | | |  | | | | | | | | | | | | | | Birth Weight: | | | | | | | |  | | | | | | Gender:  Male  Female | | | | | | | | |
| Visit Date: | | |  | | | | | | | | | | | | | Family History of Sudden Infant Death Syndrome (SIDS): Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | |
| Instructions: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Items with an asterisk (\*) require further documentation to support the answer. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vital Signs: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Temp: | | | | | | P: | | | | | | | | | R: | | | | | | | | | | WT: | | | | | Length: | | | | | | | | | Head Circ: | | |
| Nutrition Assessment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Normal | | | Abnormal | | | | | | | | Comments (All abnormal require a comment) | | | | | | | | | | | | | | | | | | | | | | | |
| Breast fed | | | | | | |  | | |  | | | | | | | | Frequency: | | | | | | | | | | | | | | | | | | | | | | | |
| Bottle fed | | | | | | |  | | |  | | | | | | | | # of feedings       / Amount | | | | | | | | | | | | | | | | | | | | | | | |
| Number of wet diapers per day: | | | | | | | | | | | | |  | | | | | | | | | | | Number of stools per day: | | | | | | | | | | | | | | | | |  |
| Adequate amount of diapers in home? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Genitalia | | | | | | |  | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Circumcised: Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extremities | | | | | | |  | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Maternal/Infant Interaction: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | Normal | | | | | | | | Abnormal | | | | | | Comments (All abnormal require a comment) | | | | | | | | | | | | | | | | | | |
| Amount of Crying | | | | | | | | |  | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | |
| Makes Eye Contact | | | | | | | | |  | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | |
| Quiet When Picked Up | | | | | | | | |  | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | |
| Nutrition: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Breast  Bottle  Breast and Bottle | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Formula: | |  | | | | | | | | | | | | | | | | | | | | | | | | Amount/Frequency: | | | | |  | | | | | | | | | | |
| Adequate amount of formula in the home? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is newborn enrolled in WIC? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Mother’s Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Health Consultant RN (Print) | | | | | | | | | | | | |  | Signature | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | |
|  | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | | |  | | | |  | |
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