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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 |
|  |
|  |
| Mother’s Name |
|  |
|  |  |  |  |  |
| Health Consultant RN (Print) |  | Signature |  | Date |
|  |  |  |  |  |
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