Community Colleges of Spokane

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