Patient Identification

Comprehensive Perinatal Services Program
POSTPARTUM COMBINED ASSESSMENT & INDIVIDUALIZED CARE PLAN (ICP)

Date:_____/_____/_____ Weeks postpartum:_____

Delivery date:_____/_____/_____ Type:_____ Infant's name:_____

Sex:____ Birthweight:_____ Weeks gestation:_____ Live Birth: Y___N___ Major anomaly: Y___N___

Abbreviations: Ecd--educated Fwd--followed HE--Health Education HO---handout N--Nutrition P--Psychosocial STT--Steps to Take Y--Yes N--No N/A--not apply (Info, F/U, R: See Guidelines)

PSYCHOSOCIAL ASSESSMENT	**ICP Interventions**	Info	FU	R
1. Do you have any questions/concerns about your delivery? ○Y ○N Describe: _____ _____ Delivery complications? ○Y ○N Describe:_____ _____	1. ○Educate to allay fears. ..... ○Ecd_____ ○Encouraged to discuss concerns with provider. ○Referral:_____ _____			
2. Do you feel comfortable about your relationship with your baby? ○Y ○N Any concerns? ○Y ○N _____ How have others adjusted to your baby? FOB:_____ Family:_____ Friends:_____ Other:_____	2. ○Ecd_____ _____ _____ _____ ○Referral:_____ _____ _____ _____			
3. Do you have concerns about?..... Finances ○Y ○N Food/clothing ○Y ○N Living accommodations ○Y ○N Baby items ○Y ○N Transportation ○Y ○N Child care ○Y ○N	3. ○Referral:_____ ○Referral:_____ _____ ○Fwd STT P 28-34 *Financial Concerns*			
4. Are you feeling?..... Lack of emotional support ○Y ○N Overwhelmed ○Y ○N "Weepy" (PP Blues) ○Y ○N Sad, depressed ○Y ○N Thoughts of harming self, baby, others ○Y ○N Other_____	4. ○Counseling referral:_____ _____ ○Ecd_____ _____ _____ _____			
5. Have you returned to work/school? ○Y ○N.....	5. _____			
6. Perinatal substance use? ○Y ○N..... Changes in use? ○Y ○N Describe: _____ _____ Alcohol_____ Street Drugs_____ Tobacco_____ _____ Prescription drugs _____	6. ○Referred to Perin. Subst. Abuse Program. ..... ○Fwd STT HE 87-91 *Drug & Alcohol Use* ..... ○Fwd STT P 65-68 *Perinatal Substance Abuse* ..... ○Ecd per STT P HO-H ..... ○Fwd STT HE 83 *Secondhand Tobacco Smoke* ..... ○Fwd STT HE 79-82 *Tobacco Use* ..... ○Ecd per STT HE HO-Q ..... _____			
7. Are you experiencing threats or abuse from your..... partner? Emotional ○Y ○N Physical ○Y ○N Sexual ○Y ○N _____ _____	7. ○Fwd STT P 53-59*Spousal/Partner Abuse* ..... ○Ecd per P HO-E, F ..... ○Referral:_____ _____			

Psychosocial Problems/Needs ***Plan*** (Developed in consultation with the patient.)

_____ _____

_____ _____

_____ _____

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HEALTH EDUCATION ASSESSMENT | **ICP Interventions**

8. Do you have questions/concerns about your..... infant care/parenting skills? ○Y ○N
_____
8. ○Encouraged to attend infant care/parenting classes.
○Referral:_____
○Ecd_____

9. Current health status:.....
Medical problems: ○Y ○N_____
Postpartum exam: ○Y ○N_____
Medication: ○Y ○N_____
Prenatal vitamins: ○Y ○N Other:_____
9. ○Ecd re: health maintenance (include Pap, Brst exams) .....
○Referral:_____
_____
_____
_____

10. Any difficulties with self care, physical changes or .... discomfort? ○Y ○N_____
_____
10. ○Ecd re: rest, exercise, personal hygiene, breast care .....
○Ecd re: involution, sexual activity_____
○_____

11. Birth control plan: ○Y ○N.....
Method chosen:_____
_____
11. ○Fwd STT HE 95-97 *Family Planning Choices* .....
○Ecd_____
○Referral:_____

12. Infant care:.....
Medical provider: ○Y ○N___ _____
Medical insurance: ○Y ○N_____
First well-baby exam: ○Y ○N_____
Any questions about infant's health? ○Y ○N
_____
Feeding method:_____
Feeding frequency/volume:_____
Problems: ○Y ○N _____
wet diapers/24 hours:_____
Car seat in use: ○Y ○N_____
12. ○Discussed access to medical and emergency care. .....
○Fwd STT HE 101-103 *Infant Safety and Health* .....
○Ecd STT HE HO-S, T
○Discussed well-child exams, immunizations. .....
○Ecd STT HE HO-U .....
○Referral:_____
○Fwd STT N 122-131 *Breastfeeding* .....
○Ecd STT N HO-AA, BB1-2, CC1-2, DD1-2, EE1-2
○ Fwd STT HE *Infant Safety Seats* .....
○Ecd_____
○Referral:_____

Health Education Problems/Needs | ***Plan*** (Developed in consultation with the patient.)

_____ _____
_____ _____
_____ _____
_____ _____

NUTRITION ASSESSMENT | **ICP Interventions**

13. Total pregnancy wt. gain_____lbs.....
Current wt._____lbs. Plotted on grid. ○Y ○N
Total wt. loss_____lbs.
13. ○Counseled on wt gain/loss .....
○Ecd STT N HO-C .....
○Ecd_____
○Referral to RD:_____

14. BP_____Change since last visit: ○Higher ○Lower
Edema ○Y ○N Other:_____
14. ○Notified medical provider. .....
○Reinforced medical recommendations. .....

15. *(**Postpartum** blood/urine obtained prior to this assessment.)*
Hgb/Hct: _____Date:_____/_____/_____
Abnormal blood/urine test results:_____
_____Date:_____/_____/_____
15. ○Reviewed lab results. .....
○Reinforced medical recommendations. .....
○ Fwd STT N 59-60 *Anemia* .....
○Ecd STT N HO-L .....
○Referred to RD:_____

16. Are you taking any of the following?.....
Prenatal vitamins ○Y ○N Iron tablets ○Y ○N
Other vitamins/minerals ○Y ○N
Herbs ○Y ○N_____
New medications ○Y ○N_____
16. ○Encouraged to continue prenatal vits. while breastfeeding.
_____
_____
_____
_____

Patient Identification

ICP Interventions

Info F/U R

17. Any change in your eating habits? ○Y ○N .....
    Do you have enough food to eat? ○Y ○N
    Enrolled in WIC? ○Y ○N ○Declined
    Infant enrolled in WIC? ○Y ○N
18. 24 Hour Diet Recall obtained below. ○Y ○N.....

17. ○Referred to food assistance:_____
    ○Referred to WIC:_____
    ○Referred to RD:_____
    ○_____
18. ○Fwd STT N 21-23 *Food Intake & Recall* .....
    ○Ecd WIC Daily Food Guide: ○ breastfeeding or
    ○age appropriate, non-pregnant
    ○Ecd_____

24 Hour Diet Recall

Time	Amount	Food & Drink	Fruits & Vegetables A C Other	Breads, Grains, Cereals	Milk	PRO	Fats Other
		Total					
		WIC Recommendations	1 1 3	7	3	3	
		Evaluation					

Comments/Nutrition Goals:

Nutrition Problems/Needs ***Plan (***Developed in consultation with the patient.)

Info FU R

_____ _____

_____ _____

_____ _____

_____ _____

Signature/Title_____ Date _____/_____/_____ Time in Minutes_____

Supervising Physician's Signature_____ Date_____/_____/_____