|  |
| --- |
| **Infant and Maternal Postpartum Assessment Form**  (Please note: The Infant and Maternal Postpartum Assessment Form is 2 pages) |

|  |
| --- |
| **Purpose:**  This form is designed to provide information about birth outcomes, initiation of breastfeeding, and the mother’s history of Urinary Tract Infections (UTIs)/Sexually Transmitted Diseases (STIs). STIs in pregnancy can harm the developing baby, depending on the type of infection. Some STIs can transfer in the birth canal during delivery; having an UTI makes women more susceptible to STIs  **General Guidelines:**   * This form is completed at the first postpartum visit or as soon after as possible. * If the client gave birth to multiples, use separate forms for each child.   **Definitions/Directions for Completing Form**  **Birthweight:**   * The NHV will usually have a discharge referral from the hospital which includes birthweight – simply enter that information here.   **Infant’s weight at newborn home visit**   * The NHV should ideally bring an accurate, calibrated infant weight scale with her to the visit so she can weigh the baby. Note: sites/societies may have organization policies that supersede this in which case a protocol should be developed re how to assess this accurately.   **Gestational age at birth:**   * For children delivered more than 3 weeks prior to client’s EDD, if this information is not provided on the hospital discharge referral, attempt to validate gestational age of the child at birth with the client’s health care provider. Otherwise, record the client’s report of what she was told was the child’s gestational age at birth.   **Does your child have any of the following health problems?**   * The information in this section informs the STAR Framework: Maternal Role Domain - Child Health and Development * The NHV may have to provide prompts for health problems such as heart problem, infection, breathing problem etc.   **UTIs/STIs questions:**   * If the client was treated for an STI during pregnancy, the NHV should assess if the client might benefit from further discussion regarding safe sex.   **Breastfeeding questions:**   * Non-exclusive breastfeeding is an indicator of poorly-established breastfeeding and this mother is at-risk of early breastfeeding cessation. The NHV should make a more detailed assessment of how breastfeeding is going for her clients. |

|  |
| --- |
| **Client Name:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client ID:** |  | **Nurse ID:** |  | **Date:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Information about baby**   1. Infant Gender  * Male * Female   days   1. Exact age of baby on day of home visit: 2. Infant’s Weight:  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Birth weight: | kilograms |  | Infant’s weight at newborn home visit: | kilograms |  1. Gestational age at birth:  |  |  | | --- | --- | | Gestational age at birth: | weeks |  1. Did (child’s name) have to spend any time in the neonatal unit (NICU) or special care nursery (SCN)?  * No * Yes * Still in NICU/SCN * Discharged home  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Number of days in NICU or SCN | days |  | Reason for neonatal admission: |  |  1. Does your child have any of the following health problems:  * Congenital disorders * Health problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Low birth weight * Preterm birth * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  1. Has (child’s name) been for a well-child check-up yet?  * Yes * No |

|  |
| --- |
| **Information about mother**  times   1. During your pregnancy, how many times were you treated for urinary tract infections?   times   1. During your pregnancy, how many times were you treated for STIs? 2. During your pregnancy, how many times did you get a prescription for antibiotics for any type of infection (other than UTIs or STIs)?   times  **Breastfeeding**   1. Are you breastfeeding or offering expressed breastmilk to your baby?  * Yes * No  1. If yes, has baby been exclusively breastfed?  * Yes * No   If no, what was the reason?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |