

POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gest Age @ Delivery:	Hospital D/C Date:
Address:			County:	
Phone Number:		Alternate Phone Number:		
Directions to Home:				

REASON FOR HOME VISIT

VISIT ATTEMPTS

(Check all that apply) <input type="checkbox"/> Under 16 years of age <input type="checkbox"/> Birth weight <input type="checkbox"/> Drugs and Alcohol <input type="checkbox"/> Other: (specify) <input type="checkbox"/> Missed hospital encounter <input type="checkbox"/> Partner Abuse <input type="checkbox"/> Mental Illness <input type="checkbox"/> No Home Visit Needed	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:50%;">Date</th> <th style="width:50%;">Type of Attempt</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Date	Type of Attempt						
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PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	Yes	No	Comments	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)
<input type="checkbox"/> Breast Care <input type="checkbox"/> Breast Feeding <input type="checkbox"/> Perineum Care <input type="checkbox"/> Hygiene <input type="checkbox"/> Nutrition <input type="checkbox"/> Incision Care <input type="checkbox"/> Bathing <input type="checkbox"/> Family Planning/Birth Control <input type="checkbox"/> Sexual Relations <input type="checkbox"/> Educational Materials/Pamphlets provided <input type="checkbox"/> Other
Comments:

SAFETY ASSESSMENT

<input type="checkbox"/> Workable Smoke Detector <input type="checkbox"/> Car Seat Available/Used <input type="checkbox"/> Inside Pets <input type="checkbox"/> Crib Safety <input type="checkbox"/> Telephone <input type="checkbox"/> Refrigeration <input type="checkbox"/> Adequate Cooling <input type="checkbox"/> Adequate Heating <input type="checkbox"/> Vermin infestation
Comments:

Visiting Nurse Signature:	Date of Visit:
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POSTPARTUM HOME VISIT SUMMARY

INFANT INFORMATION			
Infant name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth complications:	
Birth weight:	Current weight:	<input type="checkbox"/> Bottle fed <input type="checkbox"/> Breast fed	<input type="checkbox"/> Tolerates Feedings
Formula:	<input type="checkbox"/> Ounces every <input type="checkbox"/> Hour	<input type="checkbox"/> Ounces Water per day	<input type="checkbox"/> Wet Diapers per day <input type="checkbox"/> Stools per day
Medications:			
Pediatric Provider:			

INFANT PHYSICAL ASSESSMENT

Temperature:	Heart rate:			Respiratory rate:
Problems	Yes	No	Comments	
Skin: Pink nail beds/Mucous membranes				
Jaundice				
Rash				
Other				
Neurological: Lethargic				
Hyper/Hypotonic				
Crying (high pitched, non-consoling)				
Symmetrical eye movement				
Other				
Cardiovascular: Tachycardia/Bradycardia				
Irregular heart rate				
Other				
Respiratory: Rales/Rhonchi				
Cough (dry, productive, etc.)				
Nasal drainage (color, consistency)				
Other				
Gastrological: Abdominal distention				
Other				
Genitourinary: Abnormal genitalia				
Circumcision				

