Maternal Health Antepartum Home Visit Form

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| **Client Name:** |  | **Date of Service:** |  |

# Client Physical Assessment

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| **Blood Pressure** |  | **Weight** |  |
| **Headache/visual changes** |  | **Edema** |  |
| **Contractions/cramping** |  | **Vaginal bleeding/leaking of fluid/abnormal discharge** |  |
| **Fetal movement** |  | **Medication use and PNV** |  |
| **New/changed medical diagnosis** |  |
| **Home environment assessment:**  |
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# Basic Needs: Housing, Food Employment/Education

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| --- | --- | --- |
| **Does the client have:** |  |  |
|  | **Reliable transportation?*** *Yes*
* *No*
 | **Stable Housing?*** *Yes*
* *No*
 | **Adequate Utilities?*** *Yes*
* *No*
 | **Adequate Food?*** *Yes*
* *No*
 | **Is the client using WIC services?**  | * *Yes*
* *No*
 |
| **What is the client’s current living situation? Do they live alone? With family?**  |
|  |
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| **Is the client currently employed?**  | * *Yes*
* *No*
 | **Does this provide adequate income?**  | * *Yes*
* *No*
 | **Other sources of income** *(significant other, family, financial support)* |  |
|  |  |  |  |  |  |
| **Educational attainment:** | * *Less than high school*
* *High school diploma or GED*
 | * *Some college*
* *College degree or more*
 | **Language or literacy barrier?** | * *Yes*
* *No*
 |  |
| *If yes, specify* |

# Adjusting to Pregnancy and Pregnancy Support:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First Pregnancy?**  | * *Yes*
* *No*
 | **List other children:**  |  | **Is the client an adolescent?** | * *Yes*
* *No*
 |
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|  |
| **How does the client feel about this pregnancy?**  |  |
|  |
| **Any questions about family planning?**  |  |
| **Are they planning to parent this child?**  | * *Yes*
* *No*
 | **Considering adoption?**  | * *Yes*
* *No*
 | **Concerns about parenting?**  | * *Yes*
* *No*
 |  |
|  |
| *List concerns* |
| **History of parenting experience:**  |  |
|  |

|  |  |  |
| --- | --- | --- |
| **Any current fears or anxieties about the pregnancy?**  | * *Yes*
 |  |
| * *No*
 |  |
| **Does the client have a relationship with the father of the baby?**  | * *Yes*
* *No*
 | **How does the father of the baby feel about the pregnancy?**  |  |
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|  |
|  |  |  |  |
| **Is the father of the baby supportive?**  | * *Yes*
* *No*
 | **Does the client feel safe in this relationship?**  | * *Yes*
* *No*
 |
| **Is the client involved in any community activities or faith based groups?** | * *Yes*
* *No*
 |
|  |  |
| **Does the client have other family members who are supportive of the pregnancy?**  |  |
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|  |  |

# Mental Health History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Does the client have a history of any mental health concerns or diagnoses?**  | * *Yes*
* *No*
 | **Are they feeling anxious or depressed?**  | * *Yes*
* *No*
 | **Do they feel able to make plans for the future?**  | * *Yes*
* *No*
 |
| **Do they have a therapist or counselor?**  | * *Yes*
* *No*
 | **Do they have a history of substance misuse or alcohol misuse?**  | * *Yes*
* *No*
 | **Do they have a history of gambling problems?**  | * *Yes*
* *No*
 |

# Client Education

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| --- | --- | --- |
| **First Trimester Education Topics** |  | **Second Trimester Education Topics** |
| **Date:** | **Initial:**  | **Topics:** |  | **Date:** | **Initial:**  | **Topics:** |
|  |  | **Self-care & comfort measures** |  |  |  | **Importance of oral health and hygiene** |
|  |  | **Body changes and discomforts** |  |  |  | **Prenatal Care** |
|  |  | Urinary Frequency |  |  |  | Immunizations |
|  |  | Heartburn |  |  |  | **Breastfeeding introduction and feeding plans** |
|  |  | Vaginal Discharge |  |  |  |
|  |  | Nausea/Vomiting |  |  |  | **Preparing for baby** |
|  |  | Fatigue |  |  |  | Crib, car seat, diapers, bottles, clothes |
|  |  | **Alcohol and Substance Misuse during pregnancy** |  |  |  |
|  |  |  |  |  | **Safe home environment for baby** |
|  |  | Prescription drugs |  |  |  | Avoiding second hand smoke exposure |
|  |  | Alcohol |  |  |  |
|  |  | Illicit drugs |  |  |  | Handwashing |
|  |  | **Tobacco use** |  |  |  | Safe toys |
|  |  | Quitline information |  |  |  | Pet safety |
|  |  | **Seat belt safety** |  |  |  | Working smoke detectors |
|  |  | **Physical activity and nutrition (5210)** |  |  |  | **Safe Sleep introduction** |
|  |  | Weight gain |  |  |  | **Parenting classes/education** |
|  |  | **Plans for childbirth education classes** |  |  |  | **Birthing class plans; or** |
|  |  | **Infection prevention** |  |  |  | **Introduce labor and delivery education** |
|  |  | Appropriate vaccinations |  |  |  | **Family Planning/Birth Control Options** |
|  |  | Good handwashing |  |  |  | **Gestational Diabetes as needed** |
|  |  | Avoiding high risk sexual activities |  |  |  | **Fetal growth and development**  |
|  |  | Avoiding cat litter boxes |  |  |  | **Fetal Movement** |
|  |  | **Medications and teratogen avoidance and Prenatal vitamins** |  |  |  | **Danger signs:** |
|  |  |  |  |  | How and when to call OB provider: *changes in urinary function or pain, vomiting, visual changes, pain, fever, edema in hands, feet, or face, vaginal bleeding, leaking of amniotic fluid, contractions or cramps, headache, mental health symptoms*  |
|  |  | **Prenatal care appointments** |  |  |  |
|  |  | **Fetal Growth and Development** |  |  |  |
|  |  | **Danger signs:** |  |  |  |
|  |  | How and when to call OB provider: *changes in urinary function or pain, vomiting, visual changes, pain, fever, edema in hands, feet, or face, vaginal bleeding, leaking of amniotic fluid, contractions or cramps, headache, mental health symptoms*  |

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| **Third Trimester Education Topics** |
|  |  | **Fetal Growth and Development** |
|  |  | **Feeding plans and breastfeeding education** |
|  |  |
|  |  | **Safe sleep** |
|  |  | **Shaken baby** |
|  |  | **Preparing for baby** |
|  |  | Crib, car seat, diapers, bottles, clothes |
|  |  | **Safe home environment for baby** |
|  |  | Avoiding second hand smoke exposure |
|  |  | Handwashing |
|  |  | Safe toys |
|  |  | Pet safety |
|  |  | Working smoke detectors |
|  |  | **Danger signs:** |
|  |  | How and when to call OB provider: *Changes in urinary function or pain, vomiting, visual changes, pain, fever, edema in hands, feet, or face, vaginal bleeding, leaking of amniotic fluid, Preterm labor (contractions or cramps), headache, mental health symptoms*  |
|  |  | **Labor and Delivery Preparation** |
|  |  | Plan for transport to hospital |
|  |  | Signs of Labor |
|  |  | Coping strategies |
|  |  | Birth plan |
|  |  | Pain management |
|  |  | Emotional support |
|  |  | **Support for postpartum** |
|  |  | Health support (plans for transport for postpartum care needs) |
|  |  | Emotional support |
|  |  | **POST BIRTH warning signs introduction** |
|  |  | **Family Planning** |

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| **Provider:** |  | **Signature:** |  | **Date:** |  |