Maternal Health Discharge Form

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

# Discharge Survey (Delivery Outcomes)

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| --- | --- | --- | --- |
| **Child’s name:**  |  | **Gender:**  | * *Male*
* *Female*
 |
|  |  |  |
| **Child’s Race: (select all)** | * *White*
 | * *Black/African American*
 | * *American Indian/Alaska Native*
 | * *Filipino*
 |
| * *Japanese*
 | * *Korean*
 | * *Asian Indian*
 | * *Chinese*
 |
| * *Vietnamese*
 | * *Other Asian*
 | * *Native Hawaiian*
 | * *Guamanian/Chamorro*
 |
| * *Samoan*
 | * *Other Pacific Islander*
 | * *Declined*
 | * *Other*
 |
|  |
| **Child’s Ethnicity** | * *Not Hispanic/Latino*
 | * *Mexican*
 | * *Mexican American*
 |
| * *Chicano/a*
 | * *Puerto Rican*
 | * *Cuban*
 |
| * *Other Hispanic/Latinx*
 | * *Declined*
 | * *Other*
 |
|  |
| **Birth date/delivery date** |  | **Gestational age at birth**  | *weeks* |
|  |
| **Outcome** | * *Vaginal*
* *Cesarean*
 | **Birth weight** | * *VLBW <1500 grams (3lbs 50z)*
* *LBW <2500 grams (5lbs 8oz)*
* *>2500 grams*
* *LGA >4000 grams (8lbs 13oz)*
 | **Length** | *in* |
|  |
| **Abnormalities or Health Problems?**  | *Yes**No* | **If yes, describe** |  |
|  |
|  |
| **Has child died?**  | *Yes**No* | **If yes, date of death** |  |
|  |  |  |  |
| **Were services terminated prior to postpartum follow up?**  | *Yes**No* | **Will client receive postpartum home visit?** | *Yes**No* | **Is client Medicaid eligible?**  | *Yes**No* |
| **If Medicaid eligible, do you anticipate client will lose Medicaid coverage 60 days postpartum?**  | *Yes**No**Unknown* |
| **If Medicaid eligible, was education provided about possible need to obtain insurance?**  | *Yes**No**Unknown* |
| **Multiple births?**  | *Yes**No* | **If yes, how many?**  |  | **Complications with this pregnancy?**  | *Yes**No* |
| **Did the mother begin breastfeeding?**  | *Yes**No* | **Is client attending parenting education classes or receiving parenting support (e.g. home visiting)** | *Yes**No* |
| **Family Planning arrangements** | * *Birth Control Pills*
 | * *Condom*
 | * *Contraceptive Implant*
 | * *Contraceptive Ring*
 |
| * *Injections*
 | * *IUD*
 | * *Natural Family Planning*
 | * *Patch*
 |
| * *Tubal Ligation*
 | * *Vasectomy*
 | * *Other (specify)*
 |  |
| **Does client have a medical home for well woman visits?** | *Yes**No**Unknown* |

# Oral Health Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Client had a dentist visit during current pregnancy?**  | * *Yes*
 | * *No*
 | * *Unknown*
 |
| **If yes, what was the reason(s) for dentist visit?**  | * *Regular check-up or teeth cleaning*
 | * *Treatment for pain or other problem*
 | * *Unknown*
 |
| **Does client understand the need for her child to have a dentist visit by age 1?**  | * *Yes*
 | * *No*
 |

# Maternal Health Episode Information

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| --- | --- | --- | --- |
| **Closed Episode Status:**  | * *Client moved out of area*
 | * *Miscarriage/fetal death*
 | * *PE/Lactation/Oral Health*
 |
| * *Postpartum Clinic Visit*
 | * *Postpartum Home Visit*
 | * *Postpartum Phone Call Attempt*
 |
| * *Postpartum Phone Call Complete*
 | * *Program Completed*
 | * *Unable to Locate*
 |
| **End Date** |  |
| *Date of last service or phone call* |

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