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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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:** |  |