Maternal Health Postpartum Nursing Assessment/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** |  |
| **Lochia/vaginal discharge** |  | **C/S Incision** |  |
| **Episiotomy or laceration status** |  | **Medication use and PNV** |  |

# Client Mental Health Assessment

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| --- | --- |
| **Sleep Patterns:**  |  |
| **Support System/partner involvement:** |  |
| **Emotional Changes and Baby Blues:** |  |

# Infant Assessment

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| --- | --- | --- | --- |
| **Weight (grams)** |  | **Length** |  |
| **Temperature** |  | **Heart Rate** |  |
| **Respiration Rate** |  | **Skin** |  |
| **Overall Appearance** |  | **Feeding Method** |  |
| **Frequency and duration of breastfeeding** |  |
| **Frequency and amount of formula feeds** |  |

# Home Environment Assessment

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| --- | --- |
| **Infant and parent needs met?**  |  |
| **Sleep environment**  |  |
| **Car seat, other infant items?**  |  |

# 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?**  |
|  |
|  |
|  |
| **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* |
| **What is the client’s past parenting experience or with previous children?**  |  |
|  |
|  |
| **Any current fears or anxieties about the pregnancy?**  | * *Yes – describe:*
 |  |
| * *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

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| **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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| **Postpartum Education Topics** |
| **Date:** | **Initial:**  | **Topics:** |
|  |  | **Feeding plans** |
|  |  | **Breastfeeding**  |
|  |  | **Bottle Feeding** |
|  |  | **POSTBIRTH warning signs/When to call OB provider**  |
|  |  | **When to call OB provider for baby** |
|  |  | **Postpartum appointment** |
|  |  | **Family Planning options** |
|  |  | **Pediatrician Appointment** |
|  |  | **Parenting education** |
|  |  | **Emotional changes** |
|  |  | **Support systems** |
|  |  | **Referrals as needed** |
|  |  | **Safe Sleep** |
|  |  | **Infant Care** |

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