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?** | | | | | | | | | | | | | | | | | |
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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)* | | | | |  | | |
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| **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:

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| **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?** | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **Any questions about family planning?** | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **Are they planning to parent this child?** | | * *Yes* * *No* | | | **Considering adoption?** | | | | | | | * *Yes* * *No* | | | | | **Concerns about parenting?** | * *Yes* * *No* | | |  | | | | |
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| *List concerns* | | | | |
| **What is the client’s past parenting experience or with previous children?** | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **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* | | | | | | |
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| **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:** |  | |