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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02774 (05/2021) | **STATE OF WISCONSIN** |
| **PRENATAL CARE COORDINATION POSTPARTUM ASSESSMENT TOOL** |
| **Guidance** |
| * The Postpartum Assessment is an **optional** tool that provides structure for Prenatal Care Coordination (PNCC) services in the postpartum period.
* Ask the questions within the context of a conversational interview and follow-up with a discussion about important items.
* Based on the Postpartum Assessment, update the Care Plan and address identified needs with Care Coordination, Health Education and Nutrition Counseling PNCC services.
* Remember that clients have a right to choose whether or not to answer a question.
* Note strengths of the client that were evident from the conversation.
* After completing the assessment, ask clients if they have other concerns or questions that were not addressed.
 |
| **Information** |
| Client’s Name | Date of Delivery | Type of Delivery |
|       |       |       |
| Baby’s Name | Birth Weight | Birth Length |
|       |       |       |
| Baby’s Sex | Weeks Gestation |
|       |       |
| **Psychosocial** |
| Did you have any issues with delivery? [ ]  Yes [ ]  No |
|       |
| Does the baby have any medical issues? [ ]  Yes [ ]  No |
|       |
| What are you enjoying most about your new baby? |
|       |
| What is most challenging? |
|       |
| Are family members adjusting to the baby? [ ]  Yes [ ]  No |
| Are you getting the support you need from your family/partner? [ ]  Yes [ ]  No |
| Over the past 2 weeks, how often have you been bothered by any of the following problems?\* |
| 1. Little interest of pleasure in doing things:

[ ]  0 Not at all [ ]  1 Several Days [ ]  2 More than half of the days [ ]  3 Nearly every day |
| 1. Feeling down, depressed, or hopeless:

[ ]  0 Not at all [ ]  1 Several Days [ ]  2 More than half of the days [ ]  3 Nearly every day |
| How many total hours have you slept in the last 2 days? |
|       |
| Do you drink alcohol? [ ]  Yes [ ]  No |
| Do you use drugs including prescription medications? [ ]  Yes [ ]  No |
| Do you smoke cigarettes or use tobacco? [ ]  Yes [ ]  NoDoes anyone who lives in your household smoke? [ ]  Yes [ ]  NoDoes anyone who cares for your baby smoke? [ ]  Yes [ ]  No |
| Within the past year, have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you? [ ]  Yes [ ]  No |
| Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments? [ ]  Yes [ ]  No |
| What are your plans for the future related to work, school, and home? |
|       |
| Do you need help finding childcare? [ ]  Yes [ ]  No |
| Do you need essential baby supplies? [ ]  Yes [ ]  No |
| **Health Education** |
| Do you have any questions about body changes, postpartum discomforts, or self-care after pregnancy? [ ]  Yes [ ]  No |
|       |
| Are you receiving Text4Baby? [ ]  Yes [ ]  No |
| Are you using Birth control? [ ]  Yes [ ]  NoIf yes, what type?      . If no, why not?      Do you have any concerns about your ability to use birth control? [ ]  Yes [ ]  No |
| Do you have health insurance for your own health care in the future? [ ]  Yes [ ]  No |
| Did you have a postpartum medical visit? [ ]  Yes [ ]  No |
| If yes, date of visit:       If no, appointment scheduled? [ ]  Yes [ ]  No       |
| Do you have a medical provider for regular medical check-ups? [ ]  Yes [ ]  No |
| Has a doctor told you that you have any health issues that need follow-up such as diabetes, hypertension, obesity, depression? [ ]  Yes [ ]  No |
| Did you see a dentist during the pregnancy? [ ]  Yes [ ]  NoDo you have a dental visit scheduled? [ ]  Yes [ ]  No |
| Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in mouth? [ ]  Yes [ ]  No |
| Do you have a medical provider for the baby? [ ]  Yes [ ]  NoHas the baby had a check-up with a medical provider? [ ]  Yes [ ]  NoIf yes, date of visit:       If no, appointment scheduled? [ ]  Yes [ ]  No       |
| Where does the baby sleep?      What position does the baby sleep in?      What is in the baby’s sleep area (bumper pads, blankets, pillows, stuffed animals)?       |
| Do you have questions about: |
| [ ]  Newborn care[ ]  Car seat[ ]  Immunization[ ]  Safety | [ ]  Growth and development[ ]  Signs of illness[ ]  Infant nurturing[ ]  Well-child check-ups |
| **Nutrition** |
| Total Pregnancy Weight Gain | Current Weight | Client’s Weight Goal |
|       |       |       |
| Are you taking a folic acid supplement or a vitamin with folic acid? [ ]  Yes [ ]  No |
| How is infant feeding going overall? |
|       |
| What do you feed your baby? |
|       |
| How is your baby tolerating breastmilk or formula? |
|       |
| How many times in 24 hours (day and night) do you feed your baby? |
|       |
| What cues from your baby tell you that it is time for a feeding? |
|       |
| If breastfeeding, do you have concerns related to: |
| [ ]  Cracked, sore nipples[ ]  Not enough milk[ ]  Baby doesn’t take breast easily | [ ]  Pumping and storing breastmilk[ ]  Returning to work or school[ ]  Other questions |
| If formula feeding, do you have questions about preparation and storage? [ ]  Yes [ ]  No |
|       |
| Do you have a working oven, stove, refrigerator, and microwave? [ ]  Yes [ ]  No |
| Do you have running water and hot water? [ ]  Yes [ ]  No |
| Within the past 12 months, were you worried whether your food would run out before you or your family had money to buy more? [ ]  Yes [ ]  No |
| Do you receive WIC? [ ]  Yes [ ]  No |
| Do you receive SNAP? [ ]  Yes [ ]  No |
| Do you use food pantries? [ ]  Yes [ ]  No |
| On a typical day, how many servings do you eat of the following? |
| Fruit:      Vegetables:      Protein (meat, beans, eggs nuts):       | Grains:      Milk:      Beverages:       |

\*Perinatal depression screening should not be conducted within the first 2 weeks after delivery. Use a validated screening tool. The Pregnancy Health Questionnaire-2 (PHQ-2) is included on this Postpartum Assessment Tool. Clients with a total score of 3 or more should be further evaluated. Other screening tools are available at <https://the-periscope-project.org/provider-toolkit> and include the Edinburgh Postnatal Depression Scale (EPDS) and the PHQ-9.

Content adapted from the postpartum assessment tool of the California Comprehensive Perinatal Services Program.