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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-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 | | | | | | | | | |
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| 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  No  Does anyone who lives in your household smoke?  Yes  No  Does 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  No  If 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  No  Do 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  No  Has the baby had a check-up with a medical provider?  Yes  No  If 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.