|  |  |
| --- | --- |
| **CPSP Postpartum Assessment****and Individualized Care Plan**Refer to previous assessments, note any changes and update the patient’s individualized care plan | Patient Identifier |
| **Baby** | 3. Weight at birth: |  | Lbs./oz. or |  | grams |
| 1. Baby’s DOB: |  | Birth site: |  | 4. Length at birth: |  | Inches or |  | cm |
| 2. Name: |  | ❑ Male | ❑ Female | 5. Weeks gestation |  | 6. Type of delivery: |  |
| 7. If multiple births, give information on other babies: |

**Psychosocial** P/S=Priority/Status

| **Psychosocial Risks/Concerns** | **Psychosocial Individualized Care Plan Developed with Client** | **Com-ment** |
| --- | --- | --- |
| 1. Did you have any issues with delivery?❑ No ❑ Yes, describe:
 | ❑ Client goal/plan: ❑ Referred to/for: |  |
| 1. Does the baby have any medical issues?❑ No ❑ Yes, describe:
 | ❑ Client goal/plan: ❑ Referred for genetic screening before next pregnancy ❑ Referred to/for: |  |
| 1. What are you enjoying most about your new baby?

Describe:What is most challenging? Describe:  | ❑ Client goal/plan: ❑ Client discussed how to soothe the baby❑ Referred to/for: |  |
| 1. Are family members adjusting to the baby?❑ Yes ❑ No, describe:
 | ❑ Client goal/plan: ❑ Referred to/for:  |  |
| 1. Are you getting the support you need from your family/partner? ❑ Yes ❑ No, describe:
 | ❑ Client goal/plan: ❑ Client identified sources of support:❑ Referred to/for: |  |
| 1. Have you had any emotional concerns that need follow up?❑ No ❑ Yes

Over the past two weeks, have you felt down, depressed or hopeless? ❑ No ❑ Yes, describe:Have you had little interest or pleasure in doing things?❑ No ❑ Yes, describe: For the past month, more days than not, have you felt anxious, nervous, worried, irritable, or overwhelmed?❑ No ❑ Yes, describe:If you added up all of the time you have slept, how many hours would you say you have been able to sleep per day in the past two days? ❑ less than 4 hours ❑ 4-8 hours ❑ More than 8 hours/day | ❑ Client reviewed STT PSY handout: **How Bad are your Blues?**❑ Client goal/plan: ❑ Referred to OB provider ❑ Referred to Postpartum Support International 1-800-944-4PPD or postpartum.net, other: ❑ Scheduled a return visit ❑ Refer to provider if sleeping less than 4 hours/day for past two days.  |  |
| 1. Do you drink alcohol? ❑ No ❑ Yes, describe

If not breastfeeding or pregnant: >3 drinks/day, 7/week in past three months is risk.  | ❑ Client goal/plan: ❑ Will not use any alcohol if planning to become pregnant ❑ If breastfeeding, wait 3 hours after alcohol before breastfeeding or expressing milk for baby’s use.❑ Referred to/for |  |
| 1. Do you use drugs other than prescribed? ❑ No

❑ Yes, describe | ❑ Client goal/plan: ❑ Client understands to delay another pregnancy until drug free ❑ Referred to/for: |  |
| 1. Do you smoke or do people smoke around you or the baby(including e-cigarettes)?

❑ No ❑ Yes, describe | ❑ Client goal/plan: Client understands ❑ not to smoke around baby ❑ Quit for her health. ❑ Referred to/for: 1-800-no-BUTTS, other  |  |
| 1. Within the past year, has your partner hit, slapped, kicked, choked, and forced you to have sex, or otherwise physically or emotionally hurt you? ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan: Client understands: ❑ STT PSY: **Safety when Preparing to leave** ❑ **Cycle of Violence**❑ National DV hotline 1-800-799-SAFE ❑ Referred to OB provider ❑ Mandated reporting completed, date:\_\_\_\_\_\_for:\_\_\_\_\_ ❑ Local resources: |  |
| 1. What are your plans for the future: ❑ Work ❑ School ❑Home
 | ❑ Client goal/plan: ❑ Referred to/for:  |  |
| 1. Do you need help finding childcare? ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan:❑ Referred to/for:  |  |
| 1. Do you need essential baby supplies (diapers, clothing, and other supplies)? ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan:❑ Referred to/for: |  |
| 1. Do you have any other social, emotional or financial concerns? ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan:❑ Referred to/for: |  |
| 1. Reviewed the assessment with Client and identified the following strengths:
 |

**Completed by:**    **Psychosocial minutes spent:**

Signature Title Date

Signature of MD if completed by CPHW

**Health Education**

| **Health Education Risks/Concerns** | **Health Education Individualized Care Plan Developed with Client** | **Com-ment** |
| --- | --- | --- |
| 1. Do you have any questions about body changes, postpartum discomforts or self-care after pregnancy?❑ No ❑ Yes, describe:

Are you receiving Text4Baby?❑ Yes ❑ No, | ❑ Client goal/plan: ❑ Referred to OB provider❑ Client will sign up for Text4Baby |  |
| How many children are you planning to have? How far apart? Are you using birth control? ❑ Yes ❑ NoIf Yes, type If No, why not? What method(s) of birth control are you interested in? Do you have any concerns about your ability to use birth control? ❑ Forgetting to use birth control❑ Birth control could fail❑ Partner does not support her use of birth control❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Client goal/plan:❑ Discussed birth control methods, including LARCs❑ Method selected: ❑ Has family planning appointment❑ Referred to family planning provider❑ Understands emergency birth control Client will consult with OB provider: ❑ If planning to get pregnant again less than 18 months after the birth of this child.❑ If patient’s partner does not support her use of birth control, knows that there are methods partner does not have to know about. ❑ Client knows to wait at least 18 months, take folic acid, control chronic conditions, avoid chemical exposure before conceiving again, obtain preconception counseling before next pregnancy |  |
| 1. Are you exposed to chemicals or toxins at home or elsewhere? ❑ No ❑ Yes, describe
 | ❑ Client understands risks, will avoid exposure |  |
| 1. Do you have health insurance for your own health care in the future? ❑ Yes ❑ No, describe:
 | ❑ Client goal/plan:❑ Referred to clinic eligibility worker |  |
| 1. Do you have a doctor for regular medical checkups? ❑ Yes ❑ No, describe:

Primary care provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Client goal/plan:❑ Referred to/for: |  |
| 1. Has a doctor told you that you have any health issues that need follow up? (diabetes, hypertension, obesity, depression, etc.) ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan:❑ Referred to primary care provider Name  |  |
| 1. Did you see a dentist during pregnancy? ❑ Yes❑ No, describe:
 | ❑ Client goal/plan:❑ Referred to dental provider: |  |
| 1. Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in mouth? ❑ No ❑ Yes, describe:
 | ❑ Client goal/plan:Follow STT HE ❑ **Prevent Gum Problems** ❑ **See a Dentist**❑ **Keep Teeth Healthy** ❑ Referred to dental provider: |  |
| 1. Do you have a doctor and appointment for the baby?❑ Yes ❑ No

Name of provider: Appt. date:  | ❑ Client goal/plan:❑ Referred to CHDP/pediatric provider: |  |
| 1. Do you have any questions about ❑ newborn care,❑ car seat ❑ immunizations, ❑ health

❑ Where does baby sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ What position does baby sleep in?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Safety: ❑ Chemicals/cleaning supplies ❑ Electric outlets ❑ Hot water temp ❑ Exposed water (toilets, pools)❑ Other describe:  | ❑ Client goal/plan: Discussed ❑ Bathing ❑ Diapering ❑ Safe sleep ❑Other:Follow STT HE ❑ **Keep Your New Baby Safe and Healthy**❑ **Baby Needs to be Immunized** ❑ **When Newborn is Ill** ❑ Has infant car seat❑ Referred to/for❑ Client goal/plan: |  |
| 1. Do you have a dentist for the baby? ❑ Yes, ❑ No

Name of provider:  | ❑ Client goal/plan: Take baby to see dentist at first year/first tooth ❑ STT: **Protect Your Baby From Tooth Decay**❑ Referred to dental provider |  |
| 1. Other question or need? ❑ Yes, ❑No
 | ❑ Client goal/plan: |  |
| 1. Reviewed assessment with client and client identified the following strengths:
 |

**Completed by:**    **Health Ed. minutes spent:**

Signature Title Date

Signature of MD if completed by CPHW

**Nutrition**

| **Nutrition Risks/Dietary Issues** | **Nutrition Individualized Care Plan Developed with Client** | **Com-ment** |
| --- | --- | --- |
| **Anthropometric: Height, Weight, & Body Mass Index (BMI)** |
| 1. Total weight gain: lbs. Height:

Weight at this visit: lbs. BMI: Desired weight: Client’s Weight Goal: Client’s Target BMI ❑ Normal weight ❑ Underweight ❑ Overweight ❑ Obese  | Client acknowledges: ❑ Healthy weight range (18-24.9 BMI) ❑ Client’s weight goal : ❑ Aim for lower caloric intake STT **My Plate for Moms/My Nutrition Plan for Moms** or WIC **Be a Healthy Mom** handout❑ Aim to be physically active each day❑ Referral to RD (date): ❑ Referral to (profession, reason and date): ❑ Other:  |  |
| **Biochemical: Lab Values** |  |
| 1. HGB\_\_\_\_\_\_\_ HCT \_\_\_\_\_\_\_ Glucose \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Any abnormal lab values? ❑ No ❑ Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | ❑ Discussed issues with provider. Client reviewed STT N handout(s): ❑**Get The Iron You Need**❑ **If You Need Iron Pills**❑**Iron Tips** ❑**Iron Tips: Take Two**❑**My Action Plan for Iron** ❑ Referred to RD (date): ❑ Referred to (profession, reason and date): ❑ Client will: |  |
| **Clinical** |
| 1. Are there any nutrition-related health issues?

❑ Under 19 years of age ❑ Currently breastfeeding another child ❑ Diabetes ❑ Type 1 ❑Type 2 ❑ Gestational ❑ Ever had an eating disorder, such as anorexia, bulimia, disordered eating❑ Other current or previous nutrition related health issues: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Discuss issues with provider❑ Client goal/plan: ❑ Referred to RD (date): ❑ Referral to (profession, reason and date):  |  |
| **Dietary** |
| 1. Which of the following are you taking?

 Which one? How much /often? ❑ Iron ❑ Folic Acid ❑ Prenatal vitamins/minerals ❑ Other vitamins or mineral ❑ Home remedies or herbs/teas ❑ Liquid or powdered supplements ❑ Laxatives ❑ Prescription medicines ❑ Antacids ❑ Over-the-counter medicines  | ❑ Discussed issues with provider. Client reviewed STT N handout(s):❑ **Take Prenatal Vitamins and Minerals**❑ **Get the Folic Acid You Need**❑**Folic Acid: Every Woman, Every Day**\_\_\_\_\_\_\_\_\_\_\_\_❑**Get The Iron You Need**❑**If You Need Iron Pills**❑**Iron Tips\_\_\_\_\_\_\_**❑**Iron Tips: Take Two\_\_\_\_\_\_\_**❑**My Action Plan for Iron** ❑**Vitamin B12 is Important**❑**Foods Rich in Calcium**❑**You May Need Extra Calcium**❑**Constipation: What You Can Do**❑Referred to RD (date):❑Referral to (profession, reason and date)*:* ❑ Will continue prenatal vitamins until gone❑ Client acknowledges that after prenatal vitamins are gone, take vitamins with 400 micrograms folic acid❑ Client will: |  |
| 1. Are you on a special diet, including reducing or eating extra calories? ❑ No ❑ Yes, describe:

Do you limit or avoid any food or food groups (such as meat or dairy)? ❑ No ❑ Yes, describe: Why do you avoid these foods? ❑ Do not like ❑ Personal Choice ❑ Intolerance ❑ Physician advice❑ Allergy ❑ Other: | ❑ Discussed issues with provider. Client reviewed STT N handout(s): ❑ **When You Are a Vegetarian: What Do You Need To Know**❑ **Choose Healthy Foods** ❑ **Foods Rich in Calcium**❑ **Do You Have Trouble with Milk Foods?**❑ **You May Need Extra Calcium**❑ **Vitamin B12 is Important**❑ **Constipation: What You Can Do**❑ **Get the Iron You Need**❑**Get the Folic Acid You Need** ❑ Referred to: ❑ Referred to RD (date): ❑ Referral to (profession, reason and date): ❑ Client will:  |  |
| 1. How is infant feeding going overall?

  How many times in 24 hours, day and night do you feed your baby: \_\_\_\_Breastmilk \_\_\_\_\_ Formula \_\_\_\_\_Water \_\_\_\_\_Juice\_\_\_\_\_Baby Foods \_\_\_\_\_Table foods \_\_\_\_\_\_Other, Describe:\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does your baby ever go more than three hours between feedings? ❑ No ❑ Yes❑ Number wet diapers/day ❑ Number dirty diapers/day Using pacifier? ❑ Yes ❑ NoDoes baby take a supplement with vitamin D? ❑ Yes ❑ No (see guidance in care plan)Are you planning to return to work or school? ❑ No ❑ Yes, explain:If breastfeeding, are you having any of these concerns?❑ Cracked, sore nipples❑ Not enough milk❑ Baby doesn’t take breast easilyWhat breastfeeding questions can we answer today? |  Client goal/plan: follow STT N handouts:❑ **A Guide to Breastfeeding**❑ *Tips for Addressing Breastfeeding Concerns* ❑ *What to Expect while Breastfeeding: Birth to Six Weeks*❑ **Breastfeeding Checklist for My Baby and Me**❑ **Breastfeeding and Returning to Work or School**❑ **Nutrition and Breastfeeding: Common Questions and Answers** ❑ **My Breastfeeding Resources**❑Plans to exclusively breastfeed for 6 months and after 6 months, plans to continue breastfeeding with the addition of solid foods❑ Use local breastfeeding resources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ Referred to provider for Vitamin D supplement if exclusively breastfeeding or consuming less than 1 quart (32 oz.) of infant formula per day.❑ Referred to (profession, reason and date): ❑ Client will: |  |
| 1. Have you fasted while breastfeeding or do you plan to fast while breastfeeding? ❑ No ❑ Yes, describe:

❑ How often:❑ How long:  | ❑ Client goal/plan: follow ❑ **Making Plenty of Milk** *and* ❑ **How to Know your Baby is Getting Plenty of Milk** *in* **What to Expect in the First Week of Breastfeeding**❑ **You Can Pump and Store**❑ Use local breastfeeding resources: ❑ Referred to RD (date): ❑ Referral to (profession, reason and date): ❑ Client will:  |  |
| 1. Do you have the following?

❑ Oven ❑ Electricity ❑ Microwave ❑ Stove ❑ Refrigerator ❑ Clean running water❑ Missing any of the above  | Client reviewed STT N handout(s): ❑**Tips for Cooking and Storing Food**❑**When You Cannot Refrigerate, Choose These Foods**❑**Tips for Keeping Food Safe**❑ Referred to RD (date): ❑ Referred to (profession, reason and date): ❑ Client will:  |  |
| 1. In the past month, were you worried whether your food would run out before you or your family had money to buy more? ❑ No ❑ Yes, Explain:

In the past month, were there times when the food that you or your family bought just did not last and you did not have money to get more? ❑ No ❑Yes, Explain:Do you use any of the following food resources?* WIC: ❑ No ❑Yes WIC Site:
* CalFresh (food stamps)? ❑Yes ❑ No
* Have you used any other food resources, such as food banks, pantries or soup kitchen? ❑Yes ❑ No
 | Client reviewed STT N handout(s): ❑ **You Can Eat Healthy and Save Money: Tips For Food Shopping** ❑ **You Can Stretch Your Dollars: Choose These Easy Meals and Snacks**❑ **You Can Buy Low-Cost Healthy Foods**❑ Referred client to WIC ❑ Referred client to CalFresh (Food Stamps) ❑ Referred client to local emergency food resources❑ Referred to RD (date): ❑ Referred to (profession, reason and date): ❑ Client will: |  |
| 1. What kinds of physical activity do you do?

How often? How long? On an average day, are you physically active at least 30 minutes each day? ❑ Yes ❑ NoOn an average day, do you spend over 2 hours watching TV or other screen? ❑ No ❑ Yes, explain:Has a doctor told you to limit your activity? ❑ No ❑ Yes If yes, Explain:  | ❑ Client identified ways to be more active each day❑ Referred to (profession, reason and date): ❑ Client will  |  |
| 1. Complete Nutrition Assessment using one of these forms:

❑ 24-hour Perinatal Dietary Recall or❑ Perinatal Food Group Recall or❑ Approved Food Frequency Form | ❑Client identifies strengths and weaknesses demonstrated by nutrition assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client agrees to follow STT N handout(s) (indicate date): ❑**Choose Healthy Foods To Eat**❑ **Vegetarian Eating**❑**Get The Iron You Need**❑ **If You Need Iron Pills**❑ **Iron Tips** ❑**Iron Tips: Take Two**❑ **My Action Plan for Iron** ❑**Get The Folic Acid You Need**❑**Get The Vitamin B12 You Need** ❑**Food Rich in Calcium**❑**If you Had Diabetes While You Were Pregnant**❑ **Now That Your Baby Is Here**❑ **My Nutrition Plan for Moms** |  |
| 1. Other risk or dietary issue?
 | ❑ Client goal/plan: |  |
| 1. Reviewed assessment with client and client identified the following strengths:
 |

**Completed by:**    **Nutrition minutes spent:**

Signature Title Date

Signature of MD if completed by CPHW