|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 ❑ No  If 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 ❑ No  Does 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 easily  What 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 ❑ No  On 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