Patient Addressograph

# DISCHARGE/POSTPARTUM FORM

DELIVERY DATE _____ HOSPITAL _____

DISCHARGE DATE _____

## DELIVERY INFORMATION

**DELIVERY AT_____WEEKS**

☐ VAGINAL
- ☐ SVD
- ☐ VACUUM
- ☐ FORCEPS
- ☐ EPISIOTOMY
- ☐ LACERATIONS
- ☐ VBAC

☐ CESAREAN
- ☐ PRIMARY (For_____ )
- ☐ REPEAT - ELECTIVE
- ☐ REPEAT - UNSUCCESSFUL VBAC
- ☐ INCISION
  - ☐ LOW TRANSVERSE
  - ☐ LOW VERTICAL
  - ☐ CLASSICAL

TUBAL STERILIZATION ☐ YES ☐ NO

NOTES _____

DELIVERED BY_____

LABOR
- ☐ NONE
- ☐ SPONTANEOUS
- ☐ INDUCED
- ☐ AUGMENTED

ANESTHESIA
- ☐ NONE
- ☐ LOCAL/PUDENDAL
- ☐ EPIDURAL
- ☐ SPINAL
- ☐ GENERAL
- ☐ OTHER

## POSTPARTUM INFORMATION

**COMPLICATIONS**

☐ NONE ☐ HEMORRHAGE ☐ INFECTION ☐ HYPERTENSION ☐ OTHER _____

## DISCHARGE INFORMATION

**NEONATAL INFORMATION**

NAME OF BABY _____

SEX
☐ FEMALE ☐ MALE

CIRCUMCISION
☐ YES ☐ NO

BIRTH WEIGHT _____

DISPOSITION
- ☐ HOME WITH MOTHER
- ☐ IN HOSPITAL
- ☐ TRANSFER
- ☐ NEONATAL DEATH
- ☐ STILLBIRTH
- ☐ OTHER

COMPLICATIONS/ANOMALIES _____

PEDIATRICIAN _____

**MATERNAL INFORMATION**

HGB/HCT LEVEL _____

MEDICATIONS _____

FEEDING METHOD ☐ BREAST ☐ BOTTLE

CONTRACEPTIVE METHOD (IF APPLICABLE) _____

DIAGNOSTIC STUDIES PENDING _____

SECONDARY DIAGNOSIS/PREEXISTING CONDITIONS
- ☐ ASTHMA
- ☐ HYPERTENSION
- ☐ DIABETES
- ☐ OTHER _____

IMMUNIZATIONS GIVEN
- ☐ ANTI-D IMMUNE GLOBULIN
- ☐ RUBELLA
- ☐ OTHER _____

FOLLOW-UP APPT

DATE _____

LOCATION _____

OTHER _____

## INTERIM CONTACTS

| DATE | COMMENT |
|---|---|
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| | |

PROVIDER SIGNATURE (AS REQUIRED) _____



 AA197 1 2 3 4 5 / 7 6 5 4 3

## POSTPARTUM VISIT

DATE _____

LAB STUDIES REQUESTED _____

_____

HGB/HCT _____ LAST PAP TEST _____

FEEDING METHOD _____

CONTRACEPTIVE METHOD _____

POSTPARTUM DEPRESSION SCREENING _____

INTIMATE PARTNER VIOLENCE SCREENING _____

**INTERIM HISTORY**

_____

_____

_____

_____

**PHYSICAL EXAM**

BP _____ WT _____

BREASTS ☐ NORMAL _____

ABDOMEN ☐ NORMAL _____

EXTERNAL GENITALS ☐ NORMAL _____

VAGINA ☐ NORMAL _____

CERVIX ☐ NORMAL _____

UTERUS ☐ NORMAL _____

ADNEXA ☐ NORMAL _____

RECTAL-VAGINAL ☐ NORMAL _____

PAP TEST ☐ YES ☐ YES

**COMMENT**

ALLERGIES _____

MEDICATIONS/CONTRACEPTION _____

_____

☐ DISPENSED

**INTERVAL CARE RECOMMENDATIONS**

FOR GENERAL HEALTH PROMOTION _____

_____

_____

_____

_____

_____

_____

_____

FOR REPRODUCTIVE HEALTH PROMOTION _____

_____

_____

_____

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_____

RETURN VISIT _____

REFERRALS _____

_____

_____

EXAMINED BY _____

PROVIDER SIGNATURE (AS REQUIRED) _____