

Comprehensive Perinatal Services Program Postpartum Assessment and Individualized Care Plan

Client Name: Georgia Examplette Date of Birth: 01/20/1988
 Health Plan: Paperwork Health Plan ID Number: Example-9147d
 Provider: Paperwork Health Delivery Facility: Paperwork Demo Hospital
 Case Coordinator: Casey Coordination

Baby

Date of birth: _____	Baby's name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Additional Information: _____
Birth weight (lbs./oz.): _____	Birth length (inches): _____	Current weight (lbs./oz.): _____	Current length (inches): _____
Type of delivery: <input type="checkbox"/> NSVD <input type="checkbox"/> VBAC <input type="checkbox"/> Vacuum <input type="checkbox"/> Forceps <input type="checkbox"/> C-Section (<input type="checkbox"/> Primary or <input type="checkbox"/> Repeat) (<input type="checkbox"/> LTCS or <input type="checkbox"/> Classical)			

Clinical-Delivery

Individualized Care Plan

1. Delivery record filed in chart? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Intervention/Referral: <input type="checkbox"/> Contacted delivery hospital to request/follow-up on records/date: _____
2. Gestational age: _____ <input type="checkbox"/> > 37 weeks <input type="checkbox"/> < 37 weeks	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: Did You Have Complications During Pregnancy <input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> Perinatal Loss <input type="checkbox"/> Loss of Your Baby <input type="checkbox"/> Ways to Remember Your Baby <input type="checkbox"/> Referred to CHDP provider for infant follow up care: _____ <input type="checkbox"/> Referred to provider <input type="checkbox"/> Referred to: _____
3. Pregnancy/Delivery complications? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	Interventions/Referral: <input type="checkbox"/> Reviewed/discussed STT HE: Multiple Births-Twins and More
4. Client had multiple births? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Clinical-Infant

5. Infant has a pediatric provider? <input type="checkbox"/> No <input type="checkbox"/> Yes, provider: _____	Intervention/Referral: <input type="checkbox"/> Notified provider of infant health problems <input type="checkbox"/> Notified provider of infant exposure to alcohol, drugs, and/or non-prescribed medications <input type="checkbox"/> Reviewed/discussed STT PSY: Birth Defects <input type="checkbox"/> Referred to CHDP provider: _____ <input type="checkbox"/> Assisted client in scheduling infant check-up <input type="checkbox"/> Referred to Medi-Cal Managed Care Member services: _____ <input type="checkbox"/> Referred to: _____
6. Has infant had a newborn check-up? <input type="checkbox"/> Yes: Any problems? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____ <input type="checkbox"/> No: When scheduled? _____	
7. Infant prenatal exposure to: (Check all that apply) <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Non-prescribed Medication	

Clinical-Maternal

8. Have you had your postpartum check-up? <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No, when scheduled? _____	Intervention/Referral: <input type="checkbox"/> Notified provider of any health problems <input type="checkbox"/> Assisted client in scheduling a postpartum checkup: _____ <input type="checkbox"/> Referred to eligibility worker: _____ <input type="checkbox"/> Referred to: <input type="checkbox"/> Medi-Cal or <input type="checkbox"/> My Health LA <input type="checkbox"/> Referred to: _____
9. Any health problems since delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes: please explain: _____	
10. Do you have health insurance so you can receive your own health care in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Nutrition: Anthropometric

11. Total pregnancy weight gain: _____ 12. Current weight: _____ 13. Current weight category: <input type="checkbox"/> Underweight <input type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese 14. Postpartum weight goal: _____	Intervention/Referral: <input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> My Plate for Moms <input type="checkbox"/> My Nutrition Plan for Moms <input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> Safe Exercise and Lifting <input type="checkbox"/> Keep Safe When You Exercise <input type="checkbox"/> Referred to exercise & fitness resources: _____ <input type="checkbox"/> Reviewed how breastfeeding can support weight loss goals <input type="checkbox"/> Referred to Choose Health LA Moms at: ph.lacounty.gov/LAMoms <input type="checkbox"/> Referred to registered dietitian: _____ <input type="checkbox"/> Referred to: _____
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Nutrition: Biochemical (Postpartum)

<p>15. Blood – date collected: _____</p> <p>Hgb: _____ (< 10.5)</p> <p>Hct: _____ (< 32)</p> <p>16. OGTT – date: _____</p> <p>Fasting: _____ (≥ 126 mg/dL)</p> <p>2 Hr: _____ (≥ 200 mg/dL)</p> <p><input type="checkbox"/> N/A</p> <p>Comments: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Notified provider of abnormal lab values</p> <p><input type="checkbox"/> Referred to WIC: _____</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>Iron Deficiency and Other Anemias</i></p> <p><input type="checkbox"/> <i>Get the Iron You Need</i> <input type="checkbox"/> <i>Iron Tips</i> <input type="checkbox"/> <i>Iron Tips-Take Two!</i></p> <p><input type="checkbox"/> <i>My Action Plan for Iron</i></p> <p><input type="checkbox"/> Reviewed/discussed STT GDM: <i>Now That Your Baby is Here</i></p> <p><input type="checkbox"/> Discussed the importance of obtaining a checkup and preconception counseling before becoming pregnant again</p> <p><input type="checkbox"/> Referred to registered dietitian: _____</p> <p><input type="checkbox"/> Referred to: _____</p>
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Nutrition: Clinical

<p>17. Follow up needed for:</p> <p><input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> GDM</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> N/A</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to CDAPP Sweet Success Affiliate or a diabetes specialist</p> <p><input type="checkbox"/> Referred to provider</p> <p><input type="checkbox"/> Reviewed/discussed STT GDM: <input type="checkbox"/> <i>Gestational Diabetes Mellitus (GDM)</i></p> <p><input type="checkbox"/> <i>If You Had Diabetes While You Were Pregnant: Now That Your Baby is Here</i></p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Did You Have Complications During Pregnancy</i></p> <p><input type="checkbox"/> Discussed the importance of obtaining a checkup and preconception counseling before becoming pregnant again</p> <p><input type="checkbox"/> Provided Preconception Health Council of California handouts as applicable, available at: http://everywomancalifornia.org/</p>
<p>18. Are you currently taking prenatal vitamins?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Encouraged client to continue taking prenatal vitamins until gone</p> <p><input type="checkbox"/> If breastfeeding, encouraged to take vitamins with 400mcg folic acid daily</p>

Nutrition: Dietary

<p>19. Dietary intake assessment completed:</p> <p><input type="checkbox"/> Perinatal Food Group Recall (PFGR)</p> <p><input type="checkbox"/> Perinatal Food Frequency Questionnaire (PFFQ)</p> <p><input type="checkbox"/> 24-hour Perinatal Dietary Recall</p> <p>Diet adequate as assessed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>MyPlate for Moms</i> <input type="checkbox"/> <i>My Nutrition Plan for Moms</i></p> <p><input type="checkbox"/> Referred to CalFresh: _____</p> <p><input type="checkbox"/> Referred to WIC: _____</p> <p><input type="checkbox"/> Referred to food bank: _____</p> <p><input type="checkbox"/> Referred to registered dietitian: _____</p> <p><input type="checkbox"/> Notified provider</p>
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Nutrition: Infant

<p>20. What are you feeding your baby?</p> <p><input type="checkbox"/> Breastmilk only <input type="checkbox"/> Formula only <input type="checkbox"/> Breastmilk + formula</p> <p>21. Do you have questions about mixing or feeding formula?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>22. # Wet diapers/day: _____</p> <p>23. How many times in 24 hours do you feed your baby? _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>Breastfeeding</i> <input type="checkbox"/> <i>Tips for Addressing Breastfeeding Concerns</i></p> <p><input type="checkbox"/> Referred to WIC: _____</p> <p><input type="checkbox"/> Referred to breastfeeding education classes: _____</p> <p><input type="checkbox"/> Referred to breastfeeding/lactation consultant: _____</p> <p><input type="checkbox"/> Referred to breastfeeding support group: _____</p> <p><input type="checkbox"/> Referred to breastfeeding help line: _____</p> <p><input type="checkbox"/> Referred to: _____</p>
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<p>If breastfeeding: <input type="checkbox"/> N/A</p> <p>24. Is breastfeeding comfortable for you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No: _____</p> <p>25. Are you planning on returning to work or school within the next 6 months? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: _____</p> <p>26. Do you have any of the following concerns? <input type="checkbox"/> I can't tell if my baby is getting enough milk <input type="checkbox"/> My baby is not latching on well <input type="checkbox"/> I have cracked and/or sore nipples <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT NUTR: <input type="checkbox"/> <i>Breastfeeding</i> <input type="checkbox"/> <i>Tips for Addressing Breastfeeding Concerns</i> <input type="checkbox"/> <i>What to Expect While Breastfeeding: Birth to Six Weeks</i> <input type="checkbox"/> <i>Breastfeeding Checklist for Baby and Me</i> <input type="checkbox"/> <i>My Breastfeeding Resource</i> <input type="checkbox"/> <i>Nutrition and Breastfeeding: Common Questions and Answers</i></p> <p><input type="checkbox"/> Referred to Choose Health LA Moms at: ph.lacounty.gov/LAMoms <input type="checkbox"/> Referred to breastfeeding education classes: _____ <input type="checkbox"/> Referred to breastfeeding/lactation consultant: _____ <input type="checkbox"/> Referred to breastfeeding support group: _____ <input type="checkbox"/> Referred to breastfeeding help line: _____ <input type="checkbox"/> Referred to WIC for breast pump and related information: _____ <input type="checkbox"/> Provided information about Lactation Accommodation Laws <input type="checkbox"/> Referred to provider <input type="checkbox"/> Referred to childcare resources: _____ <input type="checkbox"/> Referred to: _____</p>
<p>If formula is used: <input type="checkbox"/> N/A</p> <p>27. Type of formula: _____ With Iron? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No _____ oz. _____ times/day</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Provided information about safe and appropriate bottle feeding techniques <input type="checkbox"/> Reviewed recommendations for iron-fortified formula</p>

Psychosocial

<p>28. Patient Health Questionnaire 9 (PHQ-9)</p> <p>Total Score:</p> <p><input type="checkbox"/> 0-4 (None –Minimal) <input checked="" type="checkbox"/> 5-9 (Mild) <input type="checkbox"/> 10-14 (Moderate) <input type="checkbox"/> 15-19 (Moderate Severe) <input type="checkbox"/> 20-27 (Severe)</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Notified provider of PHQ-9 score of 10 or higher <input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Emotional or Mental Health Concerns</i> <input type="checkbox"/> <i>Depression</i> <input type="checkbox"/> <i>How Bad Are Your Blues?</i> <input type="checkbox"/> Reviewed/provided “Speak Up When You’re Down” brochure <input type="checkbox"/> Encouraged client to inform provider if symptoms worsen <input type="checkbox"/> Referred to Postpartum Support International at: 1-800-944-4773 <input type="checkbox"/> Referred to mental health clinic: _____ <input type="checkbox"/> Referred to social worker: _____ <input type="checkbox"/> Referred to mental health urgent care center: _____ <input type="checkbox"/> Contacted psychiatric mobile response services at: 1-800-854-7771 <input type="checkbox"/> Contacted 911 or local law enforcement agency: _____</p>
<p>29. Are you getting the support you need from your family/partner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, explain: _____</p> <p>30. Are you having any difficulty coping with the demands of your baby? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, explain: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Parenting Stress</i> <input type="checkbox"/> <i>Emotional or Mental Health Concerns</i> <input type="checkbox"/> Referred to the National Parent Helpline at: 1-855-427-2736 <input type="checkbox"/> Referred to mental health clinic: _____ <input type="checkbox"/> Referred to family counseling/support program: _____ <input type="checkbox"/> Referred to Early Head Start (1-877-773-5543): _____ <input type="checkbox"/> Referred to AFLP (Adolescent Family Life): _____ <input type="checkbox"/> Referred to LA County Domestic Violence Hotline: 1-800-978-3600 or the National Domestic Violence Hotline: 1-800-799-7233 <input type="checkbox"/> Referred to a domestic violence shelter: _____ <input type="checkbox"/> Referred to social worker: _____ <input type="checkbox"/> Referred to: _____</p>
<p>31. Have you had any changes in your mood since your baby was born? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, please explain: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Emotional or Mental Health Concerns</i> <input type="checkbox"/> <i>Depression</i> <input type="checkbox"/> Reviewed/provided “Speak Up When You’re Down” brochure <input type="checkbox"/> Referred to Postpartum Support International at: 1-800-944-4773 <input type="checkbox"/> Referred to mental health clinic: _____ <input type="checkbox"/> Notified provider <input type="checkbox"/> Referred to social worker: _____ <input type="checkbox"/> Referred to mental health urgent care center: _____ <input type="checkbox"/> Contacted psychiatric mobile response services at: 1-800-854-7771 <input type="checkbox"/> Contacted 911 or local law enforcement agency: _____ <input type="checkbox"/> Obtained client’s signed consent to contact agency to coordinate services: Agency information: _____</p>
<p>32. a) How many hours of sleep are you getting? _____ b) Are you able to sleep when your baby is sleeping? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, please explain: _____ c) Are you able to sleep when someone else is taking care of the baby? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, please explain: _____</p>	

<p>33. Within the last year, have you been hit, slapped, kicked, choked, or otherwise physically hurt by someone?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, by whom? _____</p> <p>How many times? _____</p> <p>34. Within the last year, has anyone forced you to have sexual activities?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, by whom? _____</p> <p>How many times? _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Informed client of mandated reporting requirement if (1) she has current physical injuries from abuse, or (2) she is under the age of 18.</p> <p><input type="checkbox"/> Notified provider immediately</p> <p><input type="checkbox"/> Danger Assessment form completed by provider</p> <p><input type="checkbox"/> Completed Suspicious Injury Report</p> <p><input type="checkbox"/> Referred to a domestic violence shelter: _____</p> <p><input type="checkbox"/> Contacted local law enforcement agency: _____</p> <p><input type="checkbox"/> Referred to local law enforcement: _____</p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <input type="checkbox"/> <i>Spousal/Intimate Partner Abuse</i></p> <p><input type="checkbox"/> <i>Cycle of Violence</i> <input type="checkbox"/> <i>Safety When Preparing to Leave</i> <input type="checkbox"/> <i>Child Abuse and Neglect</i> (if under age of 18)</p> <p><input type="checkbox"/> Referred to LA County Domestic Violence Hotline: 1-800-978-3600 or the National Domestic Violence Hotline: 1-800-799-7233</p> <p><input type="checkbox"/> Referred to social worker: _____</p> <p><input type="checkbox"/> Referred to: _____</p>
<p>35. Do you feel like you have everything you need for your baby?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No: (please specify)</p> <p><input type="checkbox"/> clothing</p> <p><input type="checkbox"/> diapers</p> <p><input type="checkbox"/> a safe place to sleep</p> <p><input type="checkbox"/> childcare</p> <p><input type="checkbox"/> other: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT FS: <input type="checkbox"/> <i>Making Successful Referrals</i> <input type="checkbox"/> <i>Women, Infants and Children (WIC) Supplemental Nutrition Program</i></p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <i>Financial Concerns</i></p> <p><input type="checkbox"/> Referred to LA County Department of Social Services (DPSS): _____</p> <p><input type="checkbox"/> Referred to AFLP (Adolescent Family Life): _____</p> <p><input type="checkbox"/> Provided childcare resources: _____</p> <p><input type="checkbox"/> Provided housing resources: _____</p> <p><input type="checkbox"/> Referred to infant care supply resources: _____</p> <p><input type="checkbox"/> Referred to employment resource center: _____</p> <p><input type="checkbox"/> Referred to social worker: _____</p> <p><input type="checkbox"/> Referred to: _____</p>

Health Education

<p>36. Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in your mouth, or other oral health problems?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p> <p>37. Have you seen a dentist in the last 6 months?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to dentist: _____</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Keep Your Teeth and Mouth Healthy! Protect Your Baby Too</i></p>
<p>38. Do you have any postpartum discomforts?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to provider</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Signs and Symptoms of Heart Disease During Pregnancy and Postpartum</i></p> <p><input type="checkbox"/> Referred to Text4Baby by texting BABY or (BEBE for Spanish) to 511411</p> <p><input type="checkbox"/> Referred to: _____</p>
<p>39. Have you used drugs or medications other than as prescribed in the past year?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, explain: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Notified provider</p> <p><input type="checkbox"/> Referred to MotherToBaby at: 1-866-626-6847 or www.mothersbaby.org</p> <p><input type="checkbox"/> Encouraged client to delay another pregnancy until drug-free</p> <p><input type="checkbox"/> Referred to substance abuse treatment: _____</p> <p><input type="checkbox"/> Referred to Medi-Cal drug treatment facility: _____</p> <p><input type="checkbox"/> Referred to Narcotics Anonymous: _____</p> <p><input type="checkbox"/> Informed client of mandated reporting requirement if there is reasonable suspicion that she is abusing/neglecting her child/children</p> <p><input type="checkbox"/> Contacted LA County Child Protection Hotline: 1-800-540-4000</p> <p><input type="checkbox"/> Completed Suspected Child Abuse Report</p> <p><input type="checkbox"/> Reviewed/discussed STT PSY: <i>Child Abuse and Neglect</i></p> <p><input type="checkbox"/> Referred to: _____</p>
<p>40. Do you drink alcohol?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: <input type="checkbox"/> < 3 drinks/day/7 drinks/week in the past 3 months</p> <p><input type="checkbox"/> > 3 drinks/day/7 drinks /week in the past 3 months</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Encouraged to delay another pregnancy until alcohol-free</p> <p><input type="checkbox"/> Encouraged to wait at least 3 hours after alcohol before breastfeeding</p> <p><input type="checkbox"/> Referred to provider</p> <p><input type="checkbox"/> Referred to social worker: _____</p> <p><input type="checkbox"/> Referred to Alcoholics Anonymous: _____</p> <p><input type="checkbox"/> Referred to: _____</p>

<p>41. Do you smoke any tobacco products (including hookah or vaping), or are you exposed to secondhand smoke?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Encouraged not to allow smoke around the baby</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Tobacco Use</i> <input type="checkbox"/> <i>Second Hand Smoke</i></p> <p><input type="checkbox"/> <i>You Can Quit Smoking</i></p> <p><input type="checkbox"/> Referred to California's Smoker's Helpline: 1-800-NO-BUTTS (1-800-662-8877), or for Spanish: 1-800-NO-FUME (1-800-456-6386)</p> <p><input type="checkbox"/> Referred to provider</p> <p><input type="checkbox"/> Referred to: _____</p>
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Health Education: Family Planning

<p>42. Would you like to become pregnant within the next 18 months?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Discussed the importance of spacing 18 months between pregnancies</p> <p><input type="checkbox"/> Encouraged to take folic acid 400 mcg daily</p> <p><input type="checkbox"/> Encouraged to avoid chemical exposure before conceiving again</p> <p><input type="checkbox"/> Encouraged preconception counseling before next pregnancy</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Family Planning Choices</i></p> <p><input type="checkbox"/> Referred to Choose Health LA Moms at: ph.lacounty.gov/LAMoms</p>
<p>43. Any plans to use birth control?</p> <p><input type="checkbox"/> Yes: _____</p> <p><input type="checkbox"/> No: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Discussed birth control methods</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Family Planning Choices</i></p> <p><input type="checkbox"/> Referred to family planning provider: _____</p> <p><input type="checkbox"/> Referred to provider</p> <p><input type="checkbox"/> Referred to: _____</p>
<p>44. Has your partner ever pressured you to become pregnant, interfered with your birth control, or refused to wear a condom?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Often</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to OB or family planning provider: _____</p> <p><input type="checkbox"/> Encouraged client to talk to OB or family planning provider about birth control methods that are less detectable (such as a shot, implant, or an IUD with the strings trimmed)</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <i>Family Planning Choices</i></p> <p><input type="checkbox"/> Referred to: _____</p>

Health Education: Infant Safety & Care

<p>45. Are you around any dangerous chemicals in your household, environment, or workplace?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Workplace Safety</i> <input type="checkbox"/> <i>Keep Safe at Work</i></p> <p><input type="checkbox"/> Encouraged to avoid lead, mercury, BPA, use BPA free bottles & formula</p> <p><input type="checkbox"/> Referred to LA County Department of Public Health- Environmental Health for soil/water testing: 1-800-700-9999</p> <p><input type="checkbox"/> Referred to: _____</p>
<p>46. Do you have any questions about your baby's health or safety?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Reviewed/discussed STT HE: <input type="checkbox"/> <i>Infant Safety and Health</i> <input type="checkbox"/> <i>Oral Health During Infancy</i> <input type="checkbox"/> <i>Keeping Your Baby Safe and Healthy</i> <input type="checkbox"/> <i>Protect Your Baby From Tooth Decay</i> <input type="checkbox"/> <i>Keep Your Teeth and Mouth Healthy! Protect Your Baby, Too</i> <input type="checkbox"/> <i>When Your Newborn Baby is Ill</i> <input type="checkbox"/> <i>Your Baby Needs to be Immunized</i></p> <p><input type="checkbox"/> Discussed the importance of well-child checkups and immunizations</p> <p><input type="checkbox"/> Reviewed/discussed safe infant sleeping arrangements</p> <p><input type="checkbox"/> Reviewed "Back to Sleep" materials</p> <p><input type="checkbox"/> Referred to 1-800-745-SAFE for additional car seat safety information</p> <p><input type="checkbox"/> Referred to: _____</p>
<p>47. Would you like more information on the following topics?</p> <p><input type="checkbox"/> Infant bathing</p> <p><input type="checkbox"/> Infant diapering</p> <p><input type="checkbox"/> Safe sleep</p> <p><input type="checkbox"/> SIDS</p> <p><input type="checkbox"/> Car seat safety</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> N/A</p>	

Other

<p>48. Any other outstanding issues from the Prenatal Assessment/Reassessment?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: _____</p> <p>_____</p>	<p>Intervention/Referral:</p> <p><input type="checkbox"/> Referred to: _____</p> <p><input type="checkbox"/> Provided education on: _____</p> <p><input type="checkbox"/> Client declined follow-up</p>
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Postpartum Assessment Completed By: _____ **Date** _____ **Minutes** _____

Name & CPSP Title

Provider signature

Date

Client Strengths: _____

Postpartum Individualized Care Plan Summary

#	Problem/Risk/Concern	Client Goal	Updates & Outcomes

Client Name/ID: