Comprehensive Perinatal Services Program
Postpartum Assessment and Individualized Care Plan

Client Name:_____ Date of Birth:_____

Health Plan: _____ ID Number: _____

Provider:_____ Delivery Facility: _____

Case Coordinator: _____ Weeks Postpartum: _____

Baby

Date of birth: _____ Baby's name: _____ □ Male □ Female □ Other Additional Information: _____

Birth weight (lbs./oz.): _____ Birth length (inches): _____ Current weight (lbs./oz.): _____ Current length (inches): _____

Type of delivery: □ NSVD □ VBAC □ Vacuum □ Forceps □ C-Section (□ Primary or □ Repeat) (□ LTCS or □ Classical)

Clinical-Delivery	**Individualized Care Plan**
1. Delivery record filed in chart? □ Yes □ No	Intervention/Referral: □ Contacted delivery hospital to request/follow-up on records/date: _____
2. Gestational age: _____ □ > 37 weeks □ < 37 weeks	Intervention/Referral: □ Reviewed/discussed STT HE: ***Did You Have Complications During Pregnancy*** □ Reviewed/discussed STT PSY: □ *Perinatal Loss* □ ***Loss of Your Baby*** □ ***Ways to Remember Your Baby*** □ Referred to CPE for infant follow-up care: _____ □ Referred to provider □ Referred to:_____ □ Other:
3. Pregnancy/Delivery complications? (i.e. preeclampsia, hemorrhaging, etc.) □ No □ Yes: _____	
4. Postpartum complications. (i.e. postpartum preeclampsia, hemorrhaging, c-section complications, etc.) □ No □ Yes: _____	
5. Client had multiple births? □ No □ Yes	Interventions/Referral: □ Reviewed/discussed STT HE: *Multiple Births-Twins and More*

Clinical-Infant

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

Clinical-Maternal

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

Nutrition: Anthropometric

12. Total pregnancy weight gain: _____ 13. Current weight: _____ 14. Current weight category: □ Underweight □Normal □ Overweight □ Obese 15. Postpartum weight goal: _____	Intervention/Referral: □ Reviewed/discussed Handout: □ ***MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding*** □ Reviewed/discussed STT HE: □ *Safe Exercise and Lifting* □ ***Keep Safe When You Exercise*** □ Referred to exercise & fitness resources: _____ □ Reviewed how breastfeeding can support weight loss goals □ Referred to registered dietitian: _____ □ Referred to: _____

Nutrition: Biochemical (Postpartum)

16. Blood – date collected:_____ Hgb: _____ (< 10.5) Hct: _____ (< 32) 17. OGTT – date:_____ Fasting: _____ (≥ 126 mg/dL) 2 Hr: _____ (≥ 200 mg/dL) □ N/A Comments: _____	Intervention/Referral: □ Notified provider of abnormal lab values □ Referred to WIC: _____ □ Reviewed/discussed STT NUTR: □ *Iron Deficiency and Other Anemias* □ ***Get the Iron You Need*** □ ***Iron Tips*** □ ***Iron Tips-Take Two!*** □ ***My Action Plan for Iron*** □ Reviewed/discussed STT GDM: □ *Gestational Diabetes Mellitus (GDM)* □ ***If You Had Diabetes While You Were Pregnant: Now That Your Baby is Here*** □ Discussed the importance of obtaining a checkup and preconception counseling before becoming pregnant again □ Referred to registered dietitian: _____ □ Referred to: _____

Nutrition: Clinical

18. Follow-up needed for: □ Diabetes: □ Type 1 □ Type 2 □ GDM □ Other: _____ □ N/A	Intervention/Referral: □ Referred to a diabetes specialist □ Referred to Diabetes Prevention Program (DPP) provider at: http://publichealth.lacounty.gov/phcommon/public/nationaldpp.cfm □ Referred to provider/date:_____ □ Reviewed/discussed STT GDM: □ *Gestational Diabetes Mellitus (GDM)* □ ***If You Had Diabetes While You Were Pregnant: Now That Your Baby is Here*** □ Reviewed/discussed STT HE: ***Did You Have Complications During Pregnancy*** □ Discussed the importance of obtaining a checkup and preconception counseling before becoming pregnant again □ Provided Preconception Health Council of California handouts as applicable, available at: http://everywomancalifornia.org/
19. Are you currently taking prenatal vitamins? □ Yes □ No	Intervention/Referral: □ Encouraged client to continue taking prenatal vitamins until gone □ If chest/breastfeeding, encouraged to take vitamins with 400mcg folic acid daily

Nutrition: Dietary

20. Dietary intake assessment completed: □ Perinatal Food Group Recall (PFGR) □ Perinatal Food Group Recall *for Gestational Diabetes* (PFGR) □ Perinatal Food Frequency Questionnaire (PFFQ) □ 24-hour Perinatal Dietary Recall Diet adequate as assessed? □ Yes □ No	Intervention/Referral: □ Reviewed/discussed Handout: □ ***MyPlate for Pregnant and New Parents including Breastfeeding/MyPlan for Pregnant and New Parents including Breastfeeding*** □ Reviewed/discussed Handout: □ ***MyPlate for People with Gestational Diabetes/MyPlan for People with Gestational Diabetes*** □ Referred to CalFresh:_____ □ Referred to WIC: _____ □ Referred to food bank: _____ □ Referred to a registered dietitian if the client is lacking the minimum proportions from 2 or more food groups/date:_____ □ Notified provider

Client Name/ID:

Nutrition: Infant

21. What are you feeding your baby? □ Chest/Breastmilk only □ Formula only □ Chest/Breastmilk + formula 22. Do you have questions about mixing or feeding formula? □ Yes □ No □ N/A 23. # Wet diapers/day: _____ 24. How many times in 24 hours do you feed your baby? _____	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ Referred to WIC: _____ □ Referred to chest/breastfeeding education classes: _____ □ Referred to chest/breastfeeding/lactation consultant: _____ □ Referred to chest/breastfeeding support group: _____ □ Referred to chest/breastfeeding help line: _____ □ Referred to: _____
If Chest/Breastfeeding: □ N/A 25. Is chest/breastfeeding comfortable for you? □ Yes □ No: _____ 26. Are you planning on returning to work or school within the next 6 months? □ No □ Yes: _____ 27. Do you have any of the following concerns? □ I can't tell if my baby is getting enough milk □ My baby is not latching on well □ I have cracked and/or sore nipples □ Other: _____ □ N/A	Intervention/Referral: □ Reviewed/discussed STT NUTR: □ *Breastfeeding* □ *Tips for Addressing Breastfeeding Concerns* □ *What to Expect While Breastfeeding: Birth to Six Weeks* □ ***Breastfeeding Checklist for Baby and Me*** □**My Breastfeeding Resource** □ ***Nutrition and Breastfeeding: Common Questions and Answers*** □ Referred to breastfeeding education classes: _____ □ Referred to breastfeeding/lactation consultant: _____ □ Referred to breastfeeding support group: _____ □ Referred to breastfeeding help line: _____ □ Referred to WIC for breast pump and related information: _____ □ Provided information about Lactation Accommodation Laws □ Referred to provider □ Referred to childcare resources: _____ □ Referred to: _____
If formula is used: □ N/A 28. Type of formula: _____ With Iron? □ Yes □ No _____ oz. _____ times/day	Intervention/Referral: □ Provided information about safe and appropriate bottle feeding techniques □ Reviewed recommendations for iron-fortified formula

Psychosocial

29. Depression Screening Tool Used: □ PHQ-9 (Patient Health Questionnaire) □ EPDS (Edinburgh Perinatal Depression Screening Tool) Patient Health Questionnaire - 9 (PHQ-9) Total Score: □ 0-4 (None/Minimal) □ 5-9 (Mild) □ 10-14 (Moderate) □ 15-19 (Moderate Severe) □ 20-27 (Severe) Edinburgh Postnatal Depression Scale (EPDS) Total Score: □ 0-8 Depression not likely □ 9-11 Depression Possible □ 12-13 Fairly High Poss. of Depression □ 14-30 Probable Depression	Intervention/Referral: □ Notified provider of screening score of 5+ (PHQ-9) and 9+ (EPDS) or higher □ Notified provider of suicidal thoughts □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns* □ *Depression* □ ***How Bad Are Your Blues***? □ Provided handout: _____ □ Encouraged client to inform provider if symptoms worsen □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to social worker or mental health clinic: Date:_____ □ Referred to DMH ACCESS hotline 1-800-854-7771: Date: _____ □ Referred to local mental health urgent care clinic □ Referred to Maternal Mental Health Hotline at: 1-833-TLC-MAMA (call/text)
30. Are you getting the support you need from your family/partner? □ Yes □ No, explain: _____ 31. Are you having any difficulty coping with the demands of your baby? □ No □ Yes, explain: _____	Intervention/Referral: □ Reviewed/discussed STT PSY: □ *Parenting Stress* □ *Emotional or Mental Health Concerns* □ Referred to the National Parent Helpline at: 1-855-427-2736 □ Referred to mental health clinic: _____ □ Referred to family counseling/support program: _____ □ Referred to Early Head Start (1-877-773-5543): _____ □ Referred to AFLP (Adolescent Family Life): _____ □ Referred to LA County Domestic Violence Hotline: 1-800-978-3600 or the National Domestic Violence Hotline: 1-800-799-7233 □ Referred to a domestic violence shelter:_____ □ Referred to social worker: _____ □ Referred to: _____

Client Name/ID:

32. Have you had any changes in your mood since your baby was born? □ No □ Yes, please explain: _____ _____ 33. a) How many hours of sleep are you getting? _____ b) Are you able to sleep when your baby is sleeping? □ Yes □ No, please explain: _____ c) Are you able to sleep when someone else is taking care of the baby? □ Yes □ No, please explain: _____	Intervention/Referral: □ Reviewed/discussed STT PSY: □ *Emotional or Mental Health Concerns* □ *Depression* □ Reviewed/provided "Speak Up When You're Down" brochure □ Referred to Postpartum Support International at: 1-800-944-4773 □ Referred to mental health clinic: _____ □ Notified provider/date:_____ □ Referred to social worker/date:_____ □ Referred to DMH ACCESS hotline 1-800-854-7771/date: _____ □ Obtained client's signed consent to contact agency to coordinate services: Agency information: _____
34. Within the last year, have you been hit, slapped, kicked, choked, or otherwise physically hurt by someone? □ No □ Yes, by whom? _____ How many times? _____ 35. Within the last year, has anyone forced you to have sexual activities? □ No □ Yes, by whom? _____ How many times? _____	<u>Intervention/Referral (with or without injuries):</u> □ Informed client of mandated reporting requirement if (1) she has current physical injuries from abuse, or (2) she is under the age of 18. □ Notified provider immediately □ Reviewed/discussed STT PSY: □ *Spousal/Intimate Partner Abuse* □ ***Cycle of Violence*** □ ***Safety When Preparing to Leave*** □ *Child Abuse and Neglect* (if under age of 18) □ Referred to LA County Domestic Violence Hotline: 1-800-978-3600 or the National Domestic Violence Hotline: 1-800-799-7233 □ Referred to a domestic violence shelter/date:_____ □ Contacted local law enforcement agency: _____ □ Referred to local law enforcement: _____ □ Referred to health educator/date:_____ □ Referred to social worker/date:_____ <u>Intervention/Referral (if client reports abuse AND has injuries):</u> □ Informed client of mandated reporting requirement if (1) she has current physical injuries from abuse, or (2) she is under the age of 18. □ Notified provider immediately □ Danger Assessment form completed by provider □ Contacted local law enforcement agency/date:_____ □ Completed Suspicious Injury Report □ Filed a copy of the report in the client's medical record/date:_____
36. Do you feel like you have everything you need for your baby? □ Yes □ No: (please specify) □ clothing □ diapers □ a safe place to sleep □ childcare □ other: _____ _	Intervention/Referral: □ Reviewed/discussed STT FS: □ *Making Successful Referrals* □ *Women, Infants and Children (WIC) Supplemental Nutrition Program* □ Reviewed/discussed STT PSY: *Financial Concerns* □ Referred to LA County Department of Social Services (DPSS): _____ □ Referred to AFLP (Adolescent Family Life): _____ □ Provided childcare resources: _____ □ Provided housing resources: _____ □ Referred to infant care supply resources: _____ □ Referred to employment resource center: _____ □ Referred to social worker: _____ □ Referred to: _____

Health Education

37. Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in your mouth, or other oral health problems? □ No □ Yes: _____ 38. Have you seen a dentist in the last 6 months? □ Yes □ No	Intervention/Referral: □ Referred to dentist: _____ □ Reviewed/discussed STT HE: ***Keep Your Teeth and Mouth Healthy! Protect Your Baby Too***
39. Do you have any postpartum discomforts? □ No □ Yes: _____	Intervention/Referral: □ Referred to provider □ Reviewed/discussed STT HE: ***Signs and Symptoms of Heart Disease During Pregnancy and Postpartum*** □ Referred to Text4Baby by texting BABY or (BEBE for Spanish) to 511411 □ Referred to: _____

Client Name/ID:

40. Have you used drugs or medications other than as prescribed in the past year? □ No □ Yes, explain: _____	Intervention/Referral: □ Notified provider □ Referred to MotherToBaby at: 1-866-626-6847 or www.mothertobaby.org □ Encouraged client to delay another pregnancy until drug-free □ Referred to substance abuse treatment: _____ □ Referred to Medi-Cal drug treatment facility: _____ □ Referred to Narcotics Anonymous: _____ □ Informed client of mandated reporting requirement if there is reasonable suspicion that she is abusing/neglecting her child/children □ Contacted LA County Child Protection Hotline: 1-800-540-4000 □ Completed Suspected Child Abuse Report □ Reviewed/discussed STT PSY: *Child Abuse and Neglect* □ Referred to: _____
41. Do you drink alcohol? □ No □ Yes: □ < 3 drinks/day/7 drinks/week in the past 3 months □ > 3 drinks/day/7 drinks /week in the past 3 months	Intervention/Referral: □ Encouraged to delay another pregnancy until alcohol-free □ Encouraged to wait at least 3 hours after alcohol before chest/breastfeeding □ Referred to provider □ Referred to social worker:_____ □ Referred to Alcoholics Anonymous: _____ □ Referred to: _____
42. Do you smoke any tobacco products (including hookah or vaping), or are you exposed to secondhand smoke? □ No □ Yes: _____	Intervention/Referral: □ Encouraged not to allow smoke around the baby □ Reviewed/discussed STT HE: □ *Tobacco Use* □ *Second Hand Smoke* □ ***You Can Quit Smoking*** □ 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) □ Referred to provider □ Referred to: _____

Health Education: Family Planning

43. Would you like to become pregnant within the next 18 months? □ No □ Yes: _____	Intervention/Referral: □ Discussed the importance of spacing 18 months between pregnancies □ Encouraged to take folic acid 400 mcg daily □ Encouraged to avoid chemical exposure before conceiving again □ Encouraged preconception counseling before next pregnancy □ Reviewed/discussed STT HE: *Family Planning Choices* □ Reviewed/discussed Handout: ***MyPlate for People who May Become Pregnant***
44. Any plans to use birth control? □ Yes: _____ □ No: _____	Intervention/Referral: □ Discussed birth control methods □ Reviewed/discussed STT HE: *Family Planning Choices* □ Referred to family planning provider: _____ □ Referred to provider □ Referred to: _____
45. Has your partner ever pressured you to become pregnant, interfered with your birth control, or refused to wear a condom? □ Never □ Sometimes □ Often	Intervention/Referral: □ Referred to OB or family planning provider: _____ □ 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) □ Reviewed/discussed STT HE: *Family Planning Choices* □ Referred to: _____

Health Education: Infant Safety & Care

46. Are you around any dangerous chemicals in your household, environment, or workplace? □ No □ Yes: _____	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Workplace Safety* □ ***Keep Safe at Work*** □ Encouraged to avoid lead, mercury, BPA, use BPA free bottles & formula □ Referred to LAC Department of Public Health- Environmental Health : (888) 700-9995 □ Referred to: _____

Client Name/ID:

47. Do you have any questions about your baby's health or safety? □ No □ Yes: _____ 48. Would you like more information on the following topics? □ Infant bathing □ Infant diapering □ Safe sleep □ SIDS □ Car seat safety □ Other: _____ □ N/A	Intervention/Referral: □ Reviewed/discussed STT HE: □ *Infant Safety and Health* □ *Oral Health During Infancy* □ ***Keeping Your Baby Safe and Healthy*** □ ***Protect Your Baby From Tooth Decay*** □ ***Keep Your Teeth and Mouth Healthy! Protect Your Baby, Too*** □ ***When Your Newborn Baby is Ill*** □ ***Your Baby Needs to be Immunized*** □ Discussed the importance of well-child checkups and immunizations □ Reviewed/discussed safe infant sleeping arrangements □ Reviewed "Back to Sleep" materials □ Referred to 1-800-745-SAFE for additional car seat safety information □ Reviewed/discussed SafeKids.org □ Referred to: _____

Other

49. Any other outstanding issues from the Prenatal Assessment/Reassessment? □ No □ Yes: _____ _____	Intervention/Referral: □ Referred to: _____ □ Provided education on: _____ _____ □ Client declined follow-up

Postpartum Assessment Completed By: _____

Name & CPSP Title Date Minutes

Client Name/ID:

Provider signature: _____Date: _____

Client Strengths: _____

_____

Postpartum Individualized Care Plan Summary

#	Problem/Risk/Concern	Client Goal	Updates & Outcomes: Include date, staff name & title

Client Name/ID: