Home Visit Postpartum/Infant Assessment
Steps Ahead Maternity Care Program

Date: _____ Referral Source: _____ Referral Reason: _____

Mother's Information

Mother's Name:	Prenatal Care Provider:	Phone #:	
Address:	City:	State:	Zip:
Race:	Medicaid #:	Mother's Date of Birth:	

Infant's Information

Infant's Name:	Pediatric Provider:	
Infants Date of Birth	Sex: ☐ Male ☐ Female	Chart #

Postpartum Assessment

Medical History

Place of Delivery:

Type of Delivery:

PARA:

Birth Control Method:

Allergies:

Complications:

Medications

1.
2.
3.
4.
5.
6.

Vital Signs

B/P:

Temp:

Pulse: bpm

Resp.: bpm

Repeat B/P:

Breasts

☐ No Problem Identified
☐ Full/Engorged
☐ Cracked Nipples
☐ Redness
☐ Other:

Abdomen

☐ No Problem Identified
☐ Distention
☐ Pain
☐ Incision
☐ Drainage

Lochia

☐ No Problem Identified
☐ Foul Odor
☐ Excessive Amount
☐ Bright Red
☐ Passing Clots
☐ Other:

Bladder

☐ No Problem Identified
☐ Distention
☐ Frequency
☐ Urgency
☐ Burning
☐ Hematurnia
☐ Other:

Bowels

☐ No Problem Identified
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Pain
☐ Other:

Extremities

☐ No Problem Identified
☐ Pain
☐ Tenderness
☐ Horman's Sign
☐ Edema

Emotional Status

☐ No Problem Identified
☐ Tearful
☐ Moody
☐ Anxious
☐ Depressed
☐ Flat Affect
☐ Other:

Activity Level

☐ No Problem Identified
☐ Fatigue/ Exhaustion
☐ Sleep Disturbance
☐ Other:

Infant Assessment

Medical HX

Birth Weight:

Medications:

1.
2.
3.
4.

Infant Complications:

Feeding

Breastfeeding:
☐ Yes ☐ No

Formula Type:

Amount:

Tolerates Feedings:
☐ Good
☐ Fair
☐ Poor

Elimination

Wet Diapers - # per day:

Stools - # per day:

Consistency:
Color:

Measurements

Temp:

Pulse: bpm

Resp.: bpm

Weight:

HC:

Neuromuscular

☐ No Problem Identified
☐ Lethargic
☐ Hyper/Hypotonic
☐ Other:

Cardiovascular

☐ No Problem Identified
☐ Tachycardia/ Bradycardia
☐ Murmur
☐ Other:

Respiratory

☐ No Problem Identified
☐ Rales/Rhonchi/ Wheezing
☐ Tachypnea
☐ Other:

Head

☐ No Problem Identified
☐ Fontanels Depressed/Bulging
☐ Eye Discoloration /Drainage
☐ Nasal Drainage
☐ Thrush
☐ Other:

Skin

☐ No Problem Identified
☐ Birthmark/ Mongolian Spots
☐ Jaundice
☐ Rash
☐ Other:

Trunk

☐ No Problem Identified
☐ Abdominal Distention
☐ Abnormal Genital Appearance
☐ Other:

Umbilical Cord

☐ Drying ☐ Moist ☐ Odor
☐ Cord Off ☐ Cord Care Done
☐ Other:

Extremities

☐ No Problems Identified
☐ Asymmetrical Appearance
☐ Asymmetrical Movement
☐ Hip Click R L
☐ Extra Digit
☐ Other:

Circumcision

☐ N/A ☐ Healing ☐ Other:

Living Arrangements	Psychosocial Factors	Education
☐ With Children ☐ Spouse/FOB ☐ Parents ☐ Other:	☐ Mother Able/Willing to Provide Needed Care ☐ Father Able/Willing to Provide Needed Care ☐ Support System – Good/ Poor ☐ Bonding Well ☐ Conflict/Violence in Home ☐ Poor Previous Parenting Experience ☐ Drug/Alcohol/Tobacco Use ☐ Child Care Attainable Child Care Source: _____	Last Grade Completed: _____ ☐ Returning to School ☐ GED Completed/Seeking ☐ Other:

Environmental

Safety Assessment	Residence	Sanitation
☐ Workable Smoke Detector ☐ Care Seat Available/Used ☐ Inside Pets ☐ Baby Sleeps in Crib, Rail Space within Safety Limits ☐ Telephone ☐ Refrigerator ☐ Heating ☐ Cooling ☐ 2nd Hand Smoke Exposure	☐ House ☐ Apartment ☐ Trailer ☐ Other: _____ ☐ Structurally Sound ☐ Needs Repair ☐ Congested	☐ Clean/Well Kept ☐ Cluttered: ☐ Safe ☐ Unsafe ☐ Soiled Living Area/Foul Odor ☐ Insects/Rodents ☐ Other:

Interventions

Health Teaching (Counseling/Literature Provided): ☐ Yes ☐ No

Infant Care (Teaching/Literature Provided): ☐ Yes ☐ No

Comments/Problems/Teaching/Interventions Related to Referral Reason:

Date of Mother's PP Appointment: _____ **Location:** _____

Infant's Next Appointment: _____ **Location:** _____

Signature: _____ **Date:** _____