Steps Ahead

MISSED POSTPARTUM ENCOUNTER
HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:	Medicaid #:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gestational age @ Delivery:	Hospital D/C Date:
Address:				County:
Phone Number:		Alternate Phone Number:		
Directions to Home:				
Description of Home:				
Visit Attempts: Date _____ Attempt _____ Date _____ Attempt _____		Date _____ Attempt _____		

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	**BP:**		**Pulse:**	**Respirations:**
Problems	**Yes**	**No**	**Comments**	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)

___Breast Care ___Breast Feeding ___Perineum Care ___Hygiene ___Nutrition ___Incision Care ___Bathing

___Family Planning/Birth Control ___Sexual Relations ___Educational Materials/Pamphlets provided ___Other

Comments:

SAFETY ASSESSMENT

___Workable Smoke Detector ___Car Seat Available/Used ___Inside Pets ___Crib Safety ___Telephone

___ Refrigeration ___Adequate Cooling ____ Adequate Heating ___ Vermin infestation

Comments:

INFANT INFORMATION

Infant name:		___Male ___Female	Birth complications:
Birth weight:	Current weight:	___Bottle fed ___Breast fed	___Tolerates Feedings
Formula:	___Ounces every ____Hour	___ Ounces Water per day	___ Wet Diapers per day ___Stools per day
Medications:			
Pediatric Provider:		Patient First Form Completed:	

INFANT PHYSICAL ASSESSMENT

Temperature:	**Heart rate:**	**Respiratory rate:**

	Problems	**Yes**	**No**	**Comments**
Skin:	Pink nail beds/Mucous membranes			
	Jaundice			
	Rash			
	Other			
Neurological:	Lethargic			
	Hyper/Hypotonic			
	Crying (high pitched, non-consoling)			
	Symmetrical eye movement			
	Other			
Cardiovascular:	Tachycardia/Bradycardia			
	Irregular heart rate			
	Other			
Respiratory:	Rales/Rhonchi			
	Cough (dry, productive, etc.)			
	Nasal drainage (color, consistency)			
	Other			
Gastrological:	Abdominal distention			
	Other			
Genitourinary:	Abnormal genitalia			
	Circumcision			
	Other			
Extremities:	Adequate bilateral hand grasp			
	Hip click (right or left)			
	Other			

EDUCATION COUNSELING

Teaching: (Check areas discussed or pamphlets provided)

___General Infant Care (bathing, diapering, napping/sleeping position, holding) ___Colic ___Thermometer use ___Danger signs

___Basic Home Safety ___When to call the Doctor ___Normal Growth and Development

Mother's Post Partum Appointment/Date and Time:	**Location:**	**Mother aware:**
Infant's next Pediatric Provider Appointment:	**Location:**	**Mother aware:**
Other Appointments/Referrals Mother or infant:		

Comments/Address Reason for Home Visit:

I confirm that I received a home visit by the Steps Ahead home visit staff.

Recipient Signature:	**Date of Visit**
Visiting Nurse Signature:	**Date of Visit**

Please fax entire note back to the referring Care Coordinator
Within 3 days of visit or attempt