Steps Ahead

CARE COORDINATOR POSTPARTUM ENCOUNTER REPORT

Recipient's Name: _____ **SS#:** _____ **Medicaid#:** _____

DHCP: _____ **Risk Status** ☐ **High** ☐ **Low**

Date of Encounter	
Place of Face to Face Encounter	☐ Hospital ☐ Office
Medicaid Status	☐ Approved ☐ Plan 1st ☐ Pending ☐ Denied
If Medicaid Pending or Denied	☐ Application ☐ 295 Form ☐ Reapplication Date:_____ Site: _____
Discussed Birth Control / Plan First	☐ Yes ☐ No
Birth Control Method Chosen	☐ Pills ☐ Injection ☐ IUD ☐ Implant ☐ BTL ☐ Condoms ☐ None
Is patient on WIC?	☐ Yes ☐ No
If patient not on WIC, is WIC to be obtained for infant?	☐ Yes ☐ No
List Pediatric Provider	Pediatrician Name
Tobacco Use	☐ Yes ☐ No ☐ Quit
Alcohol/Drugs	☐ Yes ☐ No ☐ HX
Drug Treatment	☐ Yes ☐ No
Depression	☐ Yes ☐ No ☐ HX
Domestic Violence	☐ Yes ☐ No
Transportation	☐ Adequate ☐ Inadequate
Financial Support	☐ Adequate ☐ Inadequate
Housing Adequate	☐ Adequate ☐ Inadequate
Support System	☐ Good ☐ Fair ☐ Poor
Family concerns	☐ Yes _____ ☐ No
Prenatal Vitamins	Continue taking: ☐ qd ☐ 6wks
Baby Needs	Has: ☐ Car Seat ☐ Crib
SIDS/Back to Sleep	Discussed: ☐ Yes ☐ No
Breast/Bottle Feeding	Discussed: ☐ Breast ☐ Bottle
Shaken Baby Syndrome	Discussed: ☐ Yes ☐ No
Smile Alabama	Discussed: ☐ Yes ☐ No
COIIN	Form Faxed: ☐ Yes ☐ No

Infant Name: _____ **Infant's Sex:** ☐ Male ☐ Female **Infant's Weight:** _____grams

Date of Delivery: _____ **Any delivery complications?** ☐ Yes ☐ No GA @ Delivery _____ weeks

If yes, describe complication: _____

Postpartum exam: ☐ Scheduled/Date ☐ Call to schedule **Provider Name**: _____

Contacted DHR: ☐ Yes ☐ No **Infant of SSI Mother/Form Sent to Medicaid?** ☐ Yes ☐ No

Drug Screen: ☐ Yes ☐ No results _____ **Advised to notify Medicaid worker of the birth:** ☐ Yes ☐ No

Patient First Newborn Assignment Form Completed: ☐ Yes ☐ No **Postpartum info packet given and discussed:** ☐ Yes ☐ No

Notes: (include any problems identified, follow-up on problems, updates)

_____

_____

_____ _____ _____

Care Coordinator **Date** **Site**