POSTPARTUM VISIT ENCOUNTER FORM

Date: (mm/dd/yyyy) _____ Staff:_____
Child's Name: _____ HSID: _ _ _ _ -_ _ _ _-_ _
Current Age:_____ Date of Birth (mm/dd/yyyy)_____
Location of visit: ☐ Home ☐Office ☐ Clinic☐ Hospital ☐Telephone ☐ Other,Specify_____
Length of Visit _____ Minutes

Interventions Provided

☐ **Further Assessment/Screening** ☐ Specify_____

☐ Risk Identifier Maternal Component & Addendum Specify_____
☐ HS 6 month Postpartum Assessment Specify_____
☐ HS 1 Year Postpartum Assessment Specify_____
☐ HS 2 Year Postpartum Assessment Specify_____
☐ HS 3 Year ICC Assessment Specify_____
☐ HS 4 Year ICC Assessment Specify_____
☐ HS 5 Year ICC Assessment Specify_____
☐ Domestic Violence Specify_____
☐ Family Planning Status Specify_____
☐ Tobacco Use Specify_____

Is currently smoking ☐ Yes ☐ No
If Yes, client is currently pregnant or up to 6 months postpartum? ☐ Yes ☐ No
Action/Response to current smoking:
☐Delivered clear message about the benefits of quitting smoking
☐Explained and offered SCRIPT
☐Agreed to participate (Go to Script Tab) ☐Declined to participate
☐Client already participating in SCRIPT Go to SCRIPT Tab
☐Referral to Quitline/Hotline (be sure to record in referral section)
☐Other Referral (be sure to record in referral section)
☐Gave hand out/brochure
☐None , If none select reason below
☐ Client currently participating in Hotline
☐ Client currently participating in other cessation program
☐ Client not interested at this time

☐ Substance Abuse Assessment Specify_____
☐ Breastfeeding Specify_____
☐ EPDS (Pop-out Assessment Tool) ☐ Score_____ ☐ Not Competed
☐ PHQ9 (Pop-out Assessment Tool) ☐ Score_____ ☐ Not Competed
☐ Protective factors Survey (Pop-out Assessment Tool). ☐ Not Competed
☐ PICCOLO: Affection_____ Responsiveness_____ Encouragement_____ Teaching_____
☐ Other Specify_____

☐ **Administration of Immunizations,** Specify_____
☐ **Distribution of Car Seat,** Specify_____
☐ **Distribution of Breast Pump** Specify_____
☐Distribution of Barrier Methods of Contraception Specify_____
☐ **Transport to Medical/Social Services Appointment** Specify_____
☐ **Other,** Specify_____

☐ **Clinical Evaluation:**

☐ Temp: Value:_____
☐ Pulse: Value:_____
☐ Respiration: Value:_____
☐ BP: Value:_____
☐ Weight: Lbs:_____
☐ Height: Value:_____
☐ Blood Glucose Value:_____
☐ Other Value:_____

☐ **Counseling/Education/Advising:**

☐ Alcohol/Drug Use
☐ Asthma
☐ Basic Needs
☐ Behavioral & Emotional Health
☐ Breastfeeding
☐ Complications
☐ Cultural/Spiritual Aspects of Health
☐ Community Resources (WIC, ect)
☐ Depression
☐ Diabetes
☐ Domestic Violence
☐ DV Safety Plan Developed
☐ Environmental Risks
☐ Exercise, Rest, Activity
☐ Family Planning Methods
☐ Follow-up Care/Tests & Procedures
☐ Health Insurance Coverage
☐ HIV/AIDS
☐ Homelessness
☐ Hygiene
☐ Hypertension
☐ Immunizations/Pertussis
☐ Medications
☐ Mammogram/Self Breast exam
☐ Nutrition
☐ Sexually Transmitted Infections
☐ Overweight/Obesity
☐ Pain Management
☐ Pap Smear
☐ Parenting Behavior
☐ Peridontal Infection/Dental Caries
☐ Reproductive Life Plan/Child Spacing
☐ Safety, Specify_____
☐ Second Hand Smoke
☐ Stress Management
☐ Social Health & Support
☐ Tobacco Use
☐ Underweight
☐ Vaping

Handouts Provided

☐ Literature regarding covered education topics
☐ Family Spirit participant Activity Sheets, Specify___________________
☐ Other, Specify___________________________

☐ **Consult With,** Specify_________________________

☐ **Other,** Specify________________________________

Referrals

☐Referral to Specify_______________________________
Purpose___________________________ Other/Specify:________________________________
All referrals should have a progess check within 45 days, please enter the date referral progress was checked on (mm/dd/yyyy)_________________
Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
Info Source: ☐ Verified ☐ Self-Report

☐Referral to Specify_______________________________
Purpose___________________________ Other/Specify:________________________________
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Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
Info Source: ☐ Verified ☐ Self-Report

Family Spirit Modules:
First Lesson Covered

(PC) Prenatal Care	specify lesson _____
(MFM) My Family and Me	specify lesson _____
(HL) Healthy Living	specify lesson _____
IC) Infant Child	specify lesson _____
(YGC) Your Growing Child	specify lesson _____
(TC) Toddler Care	specify lesson _____

Second Lesson Covered

(PC) Prenatal Care	specify lesson _____
(MFM) My Family and Me	specify lesson _____
(HL) Healthy Living	specify lesson _____
IC) Infant Child	specify lesson _____
(YGC) Your Growing Child	specify lesson _____
(TC) Toddler Care	specify lesson _____

NOTES: