Maternity In-Home Face-to-face Post-Partum Encounter
High Risk EIs
(This encounter must occur at or between four (4) and eight (8) weeks of the delivery date)

EIs Name: _____Date of visit: _____
Care Coordinators Name:_____Title:_____
Visiting CC Signature:_____

Medicaid ID:	DOB:	Age:	Race:
Delivery Date:	Type of Delivery:		
Gestational Age at Delivery:		Hospital Discharge Date:	
Address:		County:	State:
Phone Number:			
Directions to home:			

Confirm WIC status: Active ___ Referred ___ Declined ___ Denied ___ N/A___

		Problems/Issues	Comments
Y	N	Poor previous parenting experience	
Y	N	Poor support system	
Y	N	Literate	
Y	N	Areas of anxiety noted	
Y	N	Drugs, Alcohol, Tobacco usage	
Y	N	Other health issues (hypertension, diabetes, obesity)	
Y	N	Conflict/Violence noted in the home	
Y	N	Appropriate newborn/mother attachment	
Y	N	Support system(s) present	
Y	N	Mother able/willing to provide needed infant care	
Y	N	Father able/willing to provide needed infant care	
Y	N	Emotional (tearful, moody, anxious, etc.)	
Y	N	Fatigue/Exhaustion	
Y	N	Sleep disturbance	
Y	N	Adequate living arrangements	
Y	N	Referrals made	Types of referrals:
Y	N	Sleeping arrangement for the infant	

Notes/other areas of need:

Infant #1			
Infant's Name:		Male__ Female__	Birth Complications: Yes__ No__
Birth Weight:	Current Weight:	Bottle fed___ Breast fed___	Tolerates feedings: Yes__ No__
Formula: Yes__ No__ Stools per day_____	Ounces___ every Hour(s)___ Wet diapers per day____	Ounces of water per day___	
Medications:			
PCP/Pediatrician:			
Infant #2			
Infant's Name:		Male__ Female__	Birth Complications: Yes__ No__
Birth Weight:	Current Weight:	Bottle fed___ Breast fed___	Tolerates feedings: Yes__ No__
Formula: Yes__ No__ Stools per day_____	Ounces___ every Hour(s)___ Wet diapers per day____	Ounces of water per day___	
Medications:			
PCP/Pediatrician:			

Teaching/Education/Counseling (mark all that apply)

Breast Care___ Breast Feeding___ Perineum Care___ Hygiene___ Bathing___ Incision Care___ Nutrition___
Sexual Relations___ Family Planning/Birth Control___ Educational Materials/Pamphlets provided ___ General Infant Care___ Colic___ Thermometer use___ Danger Signs___ When to call the Doctor___ Normal Growth and Development___ Day Care___ Exercise _____
Comments/Other information:

Safety Assessment (mark all that apply)

Basic Home safety___ Workable smoke detector___ Car Seat___ Crib Safety___ Telephone___ Utilities connected___ Refrigeration___ Adequate cooling___ Adequate Heating___ Vermin infestation___ Inside Pets___
Comments/Other Information:

Appointments and Referrals

Mother's Post Partum Appointment Date:	Time:	Location:	Mother aware___
Infant's next Pediatric Appointment Date:	Time:	Location:	Mother aware___
Other Appointments Mother or Infant:			
Referrals Mother or Infant:			
Comments/Address reason for visit:			