



# Maternal Health Postpartum Visit Only

Client ID: \_\_\_\_\_

Admission ID: \_\_\_\_\_

Client's name (first, middle, last) \_\_\_\_\_ Maiden name \_\_\_\_\_

Client alias \_\_\_\_\_ Alias Client ID \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ Other IDs: \_\_\_\_\_

ID Number	ID Type

Street address \_\_\_\_\_ Apt# \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Message phone \_\_\_\_\_ Message place \_\_\_\_\_ Message contact \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Race: (enter option from race table below) \_\_\_\_\_

Race:

<i>(Check all that apply)</i>		
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black	<input type="checkbox"/> unknown
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Other Pacific	<input type="checkbox"/> other specify _____
	<input type="checkbox"/> White	

Is participant of Hispanic/Latino descent?  yes  no

Country of Origin:

<input type="checkbox"/> Central America	<input type="checkbox"/> Mexico	<input type="checkbox"/> South America	<input type="checkbox"/> other specify _____
<input type="checkbox"/> Cuba	<input type="checkbox"/> Puerto Rico	<input type="checkbox"/> Unknown	

Ethnicity:

(if Hispanic/Latino)

<input type="checkbox"/> African American	<input type="checkbox"/> Asian (not Vietnamese)	<input type="checkbox"/> Haitian	<input type="checkbox"/> Somalian
<input type="checkbox"/> African (not Sudanese)	<input type="checkbox"/> Asian (Vietnamese)	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> unknown
<input type="checkbox"/> African (Sudanese)	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Jamaican	<input type="checkbox"/> other specify _____
<input type="checkbox"/> American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	
	<input type="checkbox"/> Croatian	<input type="checkbox"/> Micronesian	

Languages spoken:

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> English	<input type="checkbox"/> Sudanese	<input type="checkbox"/> other specify _____
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Serbian	<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Spanish	<input type="checkbox"/> unknown	

Is English the primary language?  yes  no  unknown

Is a translator needed?  yes  no  unknown If yes, what language? \_\_\_\_\_

Date of contact: \_\_\_\_\_

How did client hear of services? (choose all that apply)

<input type="checkbox"/> birthright	<input type="checkbox"/> juvenile court officer	<input type="checkbox"/> hospital (specify) _____
<input type="checkbox"/> care coordinator	<input type="checkbox"/> medical clinic	<input type="checkbox"/> other agency (specify) _____
<input type="checkbox"/> church	<input type="checkbox"/> other participant	<input type="checkbox"/> media (specify) _____
<input type="checkbox"/> daycare	<input type="checkbox"/> primary care provider	<input type="checkbox"/> literature (specify) _____
<input type="checkbox"/> DHS	<input type="checkbox"/> school nurse/counselor	<input type="checkbox"/> outreach (specify) _____
<input type="checkbox"/> door to door	<input type="checkbox"/> shelter	<input type="checkbox"/> other (specify) _____
<input type="checkbox"/> education/school/AEA	<input type="checkbox"/> walk-in /self-referral	
<input type="checkbox"/> family planning	<input type="checkbox"/> WIC	
<input type="checkbox"/> friend/relative	<input type="checkbox"/> unknown	

Will services be provided?  yes  no

If no, reason not served:

<input type="checkbox"/> eligibility guidelines not met	<input type="checkbox"/> not pregnant	<input type="checkbox"/> other
<input type="checkbox"/> out of service area	<input type="checkbox"/> services refused	specify _____

Client consent form signed?  yes  no

Date signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subcontractor assigned: \_\_\_\_\_ County Assigned \_\_\_\_\_

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

Primary Payment Source: (enter option from payment source table below) \_\_\_\_\_

Secondary Payment source: (check all that apply)

<input type="checkbox"/> county funds	<input type="checkbox"/> Medipass	<input type="checkbox"/> SSI	<input type="checkbox"/> other specify _____
<input type="checkbox"/> eligible/not receiving Title XIX	<input type="checkbox"/> OB indigent	<input type="checkbox"/> Title V	
<input type="checkbox"/> HawkI	<input type="checkbox"/> presumptive eligibility	<input type="checkbox"/> uninsured	
<input type="checkbox"/> Medicare	<input type="checkbox"/> private insurance	<input type="checkbox"/> unknown	
<input type="checkbox"/> Medicaid/Title XIX	<input type="checkbox"/> self-pay/sliding scale	<input type="checkbox"/> non-billable	

WIC certified?  yes  no  unknown

Employment:

<input type="checkbox"/> full time	<input type="checkbox"/> student	<input type="checkbox"/> disabled	<input type="checkbox"/> other
<input type="checkbox"/> part time	<input type="checkbox"/> self-employed	<input type="checkbox"/> temporary	<input type="checkbox"/> unknown
<input type="checkbox"/> unemployed	<input type="checkbox"/> homemaker		

Work Hours:

<input type="checkbox"/> day	<input type="checkbox"/> nights
<input type="checkbox"/> evening	<input type="checkbox"/> varies

Current marital status:

<input type="checkbox"/> divorced	<input type="checkbox"/> parent with partner	<input type="checkbox"/> single	<input type="checkbox"/> unknown
<input type="checkbox"/> married	<input type="checkbox"/> separated	<input type="checkbox"/> widowed	

Highest grade participant completed:

<input type="checkbox"/> 8th grade or less	<input type="checkbox"/> high school graduate	<input type="checkbox"/> college degree
<input type="checkbox"/> 9th grade	<input type="checkbox"/> GED	<input type="checkbox"/> technical training
<input type="checkbox"/> 10th grade	<input type="checkbox"/> some college	<input type="checkbox"/> other
<input type="checkbox"/> 11th grade		

How many children does client have? \_\_\_\_\_ Age range of children: \_\_\_\_\_

How many children are living in the home? \_\_\_\_\_

**Father Information**

Record name of baby's father and choose the code from the tables below to indicate race, ethnicity, relationship and insurance status. If the father's name is not available enter "unknown".

Name: \_\_\_\_\_

Race	Ethnicity	Relationship?	Living with participant?	Involved with pregnancy/child?	Employed?	Insurance status?
code from list	code from list	code from list	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	code from list

<p><u>Race</u></p> <p>(1) American Indian/Alaska Native                  (2) Asian                  (3) Black                  (4) Native Hawaiian/Other Pacific                  (5) White                  (6) unknown                  (7) other                  specify _____</p>	<p><u>Ethnicity</u></p> <p>(1) African American                  (2) African (not Sudanese)                  (3) African (Sudanese)                  (4) American                  (5) Asian (not Vietnamese)                  (6) Asian (Vietnamese)                  (7) Bosnian                  (8) Chinese                  (9) Haitian                  (10) Hispanic/Latino                  (11) Korean                  (12) unknown                  (13) other                  specify _____</p>	<p><u>Relationships</u></p> <p>(1) spouse                  (2) significant other                  (3) other relative                  (4) other</p>	<p><u>Insurance status</u></p> <p>(2) county funds                  (3) eligible/no Title XIX                  (6) HawkI                  (8) Medicaid/Title XIX                  (9) Medicare                  (10) Medipass                  (11) OB Indigent                  (12) presumptive eligibility                  (13) private insurance                  (14) self-pay/sliding scale                  (15) SSI                  (17) Title V                  (18) uninsured                  (19) unknown                  (20) other</p>
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Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

**Pregnancy Information**

Has the client been seen at any other agency with this pregnancy?  yes  no  unknown

Was this a planned pregnancy?  yes  no  unknown

When was pregnancy first identified?  1<sup>st</sup> trimester  2<sup>nd</sup> trimester  3<sup>rd</sup> trimester  unknown

When was first care received?  pre conception  1<sup>st</sup> trimester  2<sup>nd</sup> trimester  3<sup>rd</sup> trimester  no care

**Outcome Information**

Discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Will client receive postpartum home visit?  yes  no

Date postpartum referral was sent: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of postpartum home visit completion: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did client attend childbirth education classes?  yes  no  unknown

Attending parenting education classes?  yes  no

Delivery date \_\_\_\_/\_\_\_\_/\_\_\_\_

Multiple birth?  yes  no How many births? \_\_\_\_\_

Complications with this pregnancy?  yes  no

Did mother begin breastfeeding?  yes  no  unknown

Pregnancy Comments:

Where delivered?

<input type="checkbox"/> birthing center	<input type="checkbox"/> level I hospital	<input type="checkbox"/> U of I Hospital or Clinic
<input type="checkbox"/> clinic	<input type="checkbox"/> level II hospital	<input type="checkbox"/> unknown
<input type="checkbox"/> doctor's office	<input type="checkbox"/> level II regional hospital	<input type="checkbox"/> other
<input type="checkbox"/> home delivery	<input type="checkbox"/> level III perinatal center	specify _____

**Child Information**

	Child #1	Child #2 (twin)	Child #3 (triplet)
Child's name (first, middle, last)			
Gender	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female
Birthdate	____/____/____	____/____/____	____/____/____
Gestational age at birth (weeks)			
Outcome	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn
Type of delivery	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean
Birthweight (grams)			
Length			
ID ID Type			
Abnormalities or health problems	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Describe health problem			
Has child died?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Date of death	____/____/____	____/____/____	____/____/____

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

Does client smoke cigarettes?  yes  no  unknown

How many cigarettes per day?

<input type="checkbox"/> <1	<input type="checkbox"/> 10-20	<input type="checkbox"/> more than 2 packs
<input type="checkbox"/> 1-5	<input type="checkbox"/> 1 pack	<input type="checkbox"/> unknown
<input type="checkbox"/> 5-10	<input type="checkbox"/> 1-2 packs	

Does client drink alcohol?  yes  no  unknown

How often?  never  less than 1 drink/week  2-6 drinks/week  1 drink/day  more than 1 drink/day

Does client use illicit drugs?  yes  no  unknown  client declines

What drugs?

<input type="checkbox"/> cocaine	<input type="checkbox"/> heroin	<input type="checkbox"/> unknown
<input type="checkbox"/> crack	<input type="checkbox"/> marijuana	<input type="checkbox"/> other
<input type="checkbox"/> crank	<input type="checkbox"/> methamphetamine	specify _____

Has client been tested for HIV/AIDs?  yes  no  unknown  client declines

Were results positive?  yes  no  unknown  client declines

Does client have STDs or a history of STDs?  yes  no  unknown  client declines

What STDs?

<input type="checkbox"/> chlamydia	<input type="checkbox"/> hepatitis	<input type="checkbox"/> syphilis	<input type="checkbox"/> other specify _____
<input type="checkbox"/> cytomegalovirus	<input type="checkbox"/> herpes	<input type="checkbox"/> trichomonas	
<input type="checkbox"/> gonorrhea	<input type="checkbox"/> HPV	<input type="checkbox"/> unknown	

Is client being treated for STDs?  yes  no  unknown  client declines

Is partner being treated for STDs?  yes  no  unknown  client declines

Was client screened for domestic abuse?  yes  no  unknown

Was client screened for substance abuse?  yes  no  unknown

Was client screened for depression?  yes  no  unknown

Is client a medical risk?  yes  no  unknown

Is client a nutritional risk?  yes  no  unknown

Is client a psychosocial risk?  yes  no  unknown

Family planning arrangements:

<input type="checkbox"/> birth control pills	<input type="checkbox"/> IUD	<input type="checkbox"/> quarterly injection	<input type="checkbox"/> tubal ligation
<input type="checkbox"/> condom	<input type="checkbox"/> monthly injection	<input type="checkbox"/> rhythm method	<input type="checkbox"/> vasectomy
<input type="checkbox"/> diaphragm	<input type="checkbox"/> Norplant	<input type="checkbox"/> spermicidal foam or insert	<input type="checkbox"/> none
<input type="checkbox"/> female condom	<input type="checkbox"/> patch	<input type="checkbox"/> three month injection	<input type="checkbox"/> other specify other _____

Does client have a primary maternal care provider? (medical home)  yes  no  unknown

Does client have regular dentist?  yes  no  unknown Name of dentist: \_\_\_\_\_

When was last dentist visit?  Within 1 year  1-3 years ago  More than 3 years ago  Never seen a dentist  Unknown

Barriers to dental care:

<input type="checkbox"/> Cost	<input type="checkbox"/> Office hours	<input type="checkbox"/> Other
<input type="checkbox"/> Dentist will not accept Medicaid	<input type="checkbox"/> Fear	(specify) _____
<input type="checkbox"/> Transportation	<input type="checkbox"/> None	

Dental Insurance:

<input type="checkbox"/> Hawk-i	<input type="checkbox"/> private dental insurance	<input type="checkbox"/> other
<input type="checkbox"/> Medicaid/Title XIX	<input type="checkbox"/> self-pay	specify _____

Did client have dentist visit during pregnancy?  yes  no  unknown

If yes, what was reason(s) for dentist visit?  Regular check-up or teeth cleaning  Treatment for pain or other problem  unknown

Does client understand the need for her child to have a dentist visit by age 1?  yes  no

Does client have any oral concerns or problems?  yes  no

Specify: \_\_\_\_\_

Dental comments: \_\_\_\_\_

General comments: \_\_\_\_\_

	Name	Date
Outcome form completed by:		
Data entered by:		
Quality assurance inspection:		