

Lower Columbia College Early Head Start Post-Partum Assessment/Newborn Home Visit Form

Form for use by Public Health Nurse (EHS Health Consultant) only.

Date: _____ Mother's Name: _____ LOC ID: _____

MOTHER'S GENERAL HEALTH

Other family members present: _____

Due date: _____ Date of delivery: _____

Were there any problems during pregnancy? ☐ Y ☐ N

Did you receive prenatal care? ☐ Y ☐ N What month did you start your prenatal visits: _____

While pregnant, was your child exposed to any of the following? *(Please check all that apply)*

☐ Alcohol ☐ Caffeine ☐ Cigarettes/Tobacco ☐ Drugs ☐ Prescription Drugs

☐ Over the counter drugs: Specify: _____ ☐ Other: _____

Where was the delivery?: ☐ Hospital ☐ Home Type of Delivery?: ☐ Vaginal ☐ C-Section

Were there any problems during delivery? ☐ Y ☐ N

Were there any concerns at birth? ☐ Y ☐ N

Were there any resources shared or referrals made? ☐ Y ☐ N

How are you feeling? _____

Do you have any concerns about yourself? ☐ Y ☐ N

Do you have an appointment to be seen? ☐ Y ☐ N By whom? _____ When? _____

Respond Yes if cues are present or No if they are areas of concern.

Present	Cues	Holding	Eye Contact	Empathy	Rythmicy	Smiles
Yes	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐

BABY'S GENERAL HEALTH

Baby's name: _____ Date of Birth: _____ Sex: ☐ M ☐ F ☐ I

Weight: _____ lbs. _____ oz. Birth Length: _____ in. Head Circumference: _____ Discharge weight: _____

Did your baby have his/ her hearing checked? ☐ Y ☐ N Results: _____

Did they do a blood test for genetic disorders? ☐ Y ☐ N Has the second test been done? ☐ Y ☐ N

Did you and your infant go home from the hospital together? ☐ Y ☐ N

Has your baby been seen since discharge? ☐ Y ☐ N By whom? _____

When? _____ Why? _____ Weight? _____

Does your baby have an appointment to be seen? By whom? _____ When? _____

Your baby's health care provider will be? _____

FEEDING

Breast Feeding: every _____ hours X _____ minutes X ☐ 1 ☐ 2 ☐ 3 breast feedings

How do you know when baby is hungry? _____

How do you know when baby is full? _____

Baby cluster feeds when? _____ ☐ am ☐ pm

(C: 07/10; R: 03/17)

How do you feel breastfeeding is going? _____

What position works best for you? _____ Which breast does your baby prefer? ☐ R ☐ L

Are you supplementing with: ☐ formula ☐ water ☐ tea ☐ soothing fluids ☐ cereal

Formula: Brand: _____ with Iron ☐ ready to feed ☐ concentrated ☐ powder ☐

Every _____ hours, X _____ # ounces, X _____ minutes it takes to feed

Was this formula prescribed by your provider? ☐ Y ☐ N

What is baby's preferred position to feed in: _____ With a bottle ☐ Y ☐ N Type _____

What additional questions and/or concerns do you have about infant feedings? _____

SLEEPING

How are you putting your baby to sleep? ☐ back ☐ side ☐ tummy

How long is your baby sleeping (on average): _____ hours ☐ am ☐ pm

Are you using blankets with the baby? ☐ Y ☐ N

Does the baby have his/her own bed or is baby sharing a bed with someone? _____

GENERAL CARE

Do you have any concerns at this time about cord care, circumcision, bathing? ☐ Y ☐ N

How many wet diapers has your baby had since yesterday? _____ How many dirty? _____ Color? _____

Do you have any concerns about your baby? ☐ Y ☐ N

SAFETY

Do you have any safety concerns or questions? _____

FAMILY NEEDS AND SUPPORT

Do you or your family members have any other concerns or needs you would like to talk about or would like help with? _____

Resources Shared/Referrals Made/Discussion/Comments

Follow-Up For Staff

Parent's Signature _____

Date _____

Registered Nurse (EHS Health Consultant) Signature _____

Date _____