CPSP Postpartum Assessment and Individualized Care Plan
Refer to previous assessments, note any changes and update the patient's individualized care plan

Patient Identifier

Baby

1. Baby's DOB: _____ Birth site: _____

2. Name: _____ ❑ Male ❑ Female

3. Weight at birth: _____ Lbs./oz. or _____ grams

4. Length at birth: _____ Inches or _____ cm

5. Weeks gestation _____ 6. Type of delivery: _____

7. If multiple births, give information on other babies:

Psychosocial

Psychosocial Risks/Concerns	Psychosocial Individualized Care Plan Developed with Client	Comment
1. Did you have any issues with delivery? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to/for:	
2. Does the baby have any medical issues? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred for genetic screening before next pregnancy ❑ Referred to/for:	
3. What are you enjoying most about your new baby? Describe: What is most challenging? Describe:	❑ Client goal/plan: ❑ Client discussed how to soothe the baby ❑ Referred to/for:	
4. Are family members adjusting to the baby? ❑ Yes ❑ No, describe:	❑ Client goal/plan: ❑ Referred to/for:	
5. Are you getting the support you need from your family/partner? ❑ Yes ❑ No, describe:	❑ Client goal/plan: ❑ Client identified sources of support: ❑ Referred to/for:	
6. Have you had any emotional concerns that need follow up? ❑ No ❑ Yes Over the past two weeks, have you felt down, depressed or hopeless? ❑ No ❑ Yes, describe: Have you had little interest or pleasure in doing things? ❑ No ❑ Yes, describe: For the past month, more days than not, have you felt anxious, nervous, worried, irritable, or overwhelmed? ❑ No ❑ Yes, describe: If you added up all of the time you have slept, how many hours would you say you have been able to sleep per day in the past two days? ❑ less than 4 hours ❑ 4-8 hours ❑ More than 8 hours/day	❑ Client reviewed STT PSY handout: **How Bad are your Blues?** ❑ Client goal/plan: ❑ Referred to OB provider ❑ Referred to Postpartum Support International 1-800-944-4PPD or postpartum.net, other: ❑ Scheduled a return visit ❑ Refer to provider if sleeping less than 4 hours/day for past two days.	
7. Do you drink alcohol? ❑ No ❑ Yes, describe If not breastfeeding or pregnant: >3 drinks/day, 7/week in past three months is risk.	❑ Client goal/plan: ❑ Will not use any alcohol if planning to become pregnant ❑ If breastfeeding, wait 3 hours after alcohol before breastfeeding or expressing milk for baby's use. ❑ Referred to/for	
8. Do you use drugs other than prescribed? ❑ No ❑ Yes, describe	❑ Client goal/plan: ❑ Client understands to delay another pregnancy until drug free ❑ Referred to/for:	

Psychosocial Risks/Concerns	Psychosocial Individualized Care Plan Developed with Client	Com-ment
9. Do you smoke or do people smoke around you or the baby(including e-cigarettes)? ❑ No ❑ Yes, describe	❑ Client goal/plan: Client understands ❑ not to smoke around baby ❑ Quit for her health. ❑ Referred to/for: 1-800-no-BUTTS, other_____	
10. Within the past year, has your partner hit, slapped, kicked, choked, and forced you to have sex, or otherwise physically or emotionally hurt you? ❑ No ❑ Yes, describe:	❑ Client goal/plan: Client understands: ❑ STT PSY: **Safety when Preparing to leave ❑ Cycle of Violence** ❑ National DV hotline 1-800-799-SAFE ❑ Referred to OB provider ❑ Mandated reporting completed, date:_____for:_____ ❑ Local resources:	
11. What are your plans for the future: ❑ Work ❑ School ❑Home	❑ Client goal/plan: ❑ Referred to/for:	
12. Do you need help finding childcare? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to/for:	
13. Do you need essential baby supplies (diapers, clothing, and other supplies)? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to/for:	
14. Do you have any other social, emotional or financial concerns? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to/for:	
15. Reviewed the assessment with Client and identified the following strengths:		

Completed by:_____ _____ _____ **Psychosocial minutes spent:** _

Signature Title Date

Signature of MD if completed by CPHW_____

Health Education

Health Education Risks/Concerns	Health Education Individualized Care Plan Developed with Client	Com-ment
1. Do you have any questions about body changes, postpartum discomforts or self-care after pregnancy? ❑ No ❑ Yes, describe: Are you receiving Text4Baby? ❑ Yes ❑ No,	❑ Client goal/plan: ❑ Referred to OB provider ❑ Client will sign up for Text4Baby	
2. How many children are you planning to have?_____ How far apart?_____ Are you using birth control? ❑ Yes ❑ No If Yes, type_____ If No, why not?_____ What method(s) of birth control are you interested in? Do you have any concerns about your ability to use birth control? ❑ Forgetting to use birth control ❑ Birth control could fail ❑ Partner does not support her use of birth control ❑ Other:	Client goal/plan: ❑ Discussed birth control methods, including LARCs ❑ Method selected: _____ ❑ Has family planning appointment ❑ Referred to family planning provider ❑ Understands emergency birth control Client will consult with OB provider: ❑ If planning to get pregnant again less than 18 months after the birth of this child. ❑ If patient's partner does not support her use of birth control, knows that there are methods partner does not have to know about. ❑ Client knows to wait at least 18 months, take folic acid, control chronic conditions, avoid chemical exposure before conceiving again, obtain preconception counseling before next pregnancy	
3. Are you exposed to chemicals or toxins at home or elsewhere? ❑ No ❑ Yes, describe	❑ Client understands risks, will avoid exposure	
4. Do you have health insurance for your own health care in the future? ❑ Yes ❑ No, describe:	❑ Client goal/plan: ❑ Referred to clinic eligibility worker	
5. Do you have a doctor for regular medical checkups? ❑ Yes ❑ No, describe: Primary care provider name: _____	❑ Client goal/plan: ❑ Referred to/for:	
6. Has a doctor told you that you have any health issues that need follow up? (diabetes, hypertension, obesity, depression, etc.) ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to primary care provider Name_____ _____	
7. Did you see a dentist during pregnancy? ❑ Yes ❑ No, describe:	❑ Client goal/plan: ❑ Referred to dental provider:	
8. Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in mouth? ❑ No ❑ Yes, describe:	❑ Client goal/plan: Follow STT HE ❑ **Prevent Gum Problems** ❑ **See a Dentist** ❑ **Keep Teeth Healthy** ❑ Referred to dental provider:	
9. Do you have a doctor and appointment for the baby? ❑ Yes ❑ No Name of provider:_____Appt. date: _____	❑ Client goal/plan: ❑ Referred to CHDP/pediatric provider:	

Health Education Risks/Concerns	Health Education Individualized Care Plan Developed with Client	Com-ment
10. Do you have any questions about ❑ newborn care, ❑ car seat ❑ immunizations, ❑ health ❑ Where does baby sleep? _____ ❑ What position does baby sleep in?_____ Safety: ❑ Chemicals/cleaning supplies ❑ Electric outlets ❑ Hot water temp ❑ Exposed water (toilets, pools) ❑ Other describe:_____	❑ Client goal/plan: Discussed ❑ Bathing ❑ Diapering ❑ Safe sleep ❑Other: Follow STT HE ❑ **Keep Your New Baby Safe and Healthy** ❑ **Baby Needs to be Immunized** ❑ **When Newborn is Ill** ❑ Has infant car seat ❑ Referred to/for ❑ Client goal/plan:	
11. Do you have a dentist for the baby? ❑ Yes, ❑ No Name of provider:	❑ Client goal/plan: Take baby to see dentist at first year/first tooth ❑ STT: **Protect Your Baby From Tooth Decay** ❑ Referred to dental provider	
12. Other question or need? ❑ Yes, ❑No	❑ Client goal/plan:	
13. Reviewed assessment with client and client identified the following strengths:		

Completed by:_____ _____ _____ **Health Ed. minutes spent:** ____

Signature Title Date

Signature of MD if completed by CPHW_____

Nutrition

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Com-ment
Anthropometric: Height, Weight, & Body Mass Index (BMI)		
1. Total weight gain:_____ lbs. Height: _____ Weight at this visit: ____lbs. BMI: _____ Desired weight:_____ Client's Weight Goal: _____ Client's Target BMI_____ ❑ Normal weight ❑ Underweight ❑ Overweight ❑ Obese	Client acknowledges: ❑ Healthy weight range (18-24.9 BMI) ❑ Client's weight goal : _____ ❑ Aim for lower caloric intake STT **My Plate for Moms/My Nutrition Plan for Moms** or WIC **Be a Healthy Mom** handout ❑ Aim to be physically active each day ❑ Referral to RD (date): _____ ❑ Referral to (profession, reason and date): _____ _____	
Biochemical: Lab Values		
2. HGB_____ HCT _____ Glucose _____ Date: _____ Any abnormal lab values? ❑ No ❑ Yes, describe: _____	❑ Discussed issues with provider. Client reviewed STT N handout(s): ❑ **Get The Iron You Need** ❑ **If You Need Iron Pills** ❑**Iron Tips** ❑**Iron Tips: Take Two** ❑**My Action Plan for Iron** ❑ Referred to RD (date): _____ ❑ Referred to (profession, reason and date): _____ _____ ❑ Client will:	
Clinical		
3. Are there any nutrition-related health issues? ❑ Under 19 years of age ❑ Currently breastfeeding another child ❑ Diabetes ❑ Type 1 ❑Type 2 ❑ Gestational ❑ Ever had an eating disorder, such as anorexia, bulimia, disordered eating ❑ Other current or previous nutrition related health issues: _____	❑ Discuss issues with provider ❑ Client goal/plan: ❑ Referred to RD (date):_____ ❑ Referral to (profession, reason and date): _____ _____	
Dietary		
4. Which of the following are you taking? Which one? / How much /often? ❑ Iron _____ _____ ❑ Folic Acid _____ _____ ❑ Prenatal vitamins/minerals _____ _____ ❑ Other vitamins or mineral _____ _____ ❑ Home remedies or herbs/teas _____ _____ ❑ Liquid or powdered supplements_____ _____ ❑ Laxatives _____ _____ ❑ Prescription medicines _____ _____ ❑ Antacids _____ _____ ❑ Over-the-counter medicines _____ _____	❑ Discussed issues with provider. Client reviewed STT N handout(s): ❑ **Take Prenatal Vitamins and Minerals** ❑ **Get the Folic Acid You Need** ❑**Folic Acid: Every Woman, Every Day**_____ ❑ **Get The Iron You Need** ❑ **If You Need Iron Pills** ❑**Iron Tips**_____❑**Iron Tips: Take Two**_____ ❑**My Action Plan for Iron** ❑ **Vitamin B12 is Important** ❑ **Foods Rich in Calcium** ❑ **You May Need Extra Calcium** ❑ **Constipation: What You Can Do** ❑ Referred to RD (date):_____ ❑ Referral to (profession, reason and date):_____ ❑ Will continue prenatal vitamins until gone ❑ Client acknowledges that after prenatal vitamins are gone, take vitamins with 400 micrograms folic acid ❑ Client will:	

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Com-ment
5. Are you on a special diet, including reducing or eating extra calories? ❑ No ❑ Yes, describe:_____ _____ Do you limit or avoid any food or food groups (such as meat or dairy)? ❑ No ❑ Yes, describe:_____ _____ Why do you avoid these foods? ❑ Do not like ❑ Personal Choice ❑ Intolerance ❑ Physician advice ❑ Allergy ❑ Other:	❑ Discussed issues with provider. Client reviewed STT N handout(s): ❑ **When You Are a Vegetarian: What Do You Need To Know** ❑ **Choose Healthy Foods** ❑ **Foods Rich in Calcium** ❑ **Do You Have Trouble with Milk Foods?** ❑ **You May Need Extra Calcium** ❑ **Vitamin B12 is Important** ❑ **Constipation: What You Can Do** ❑ **Get the Iron You Need** ❑ **Get the Folic Acid You Need** ❑ Referred to: _____ ❑ Referred to RD (date): _____ ❑ Referral to (profession, reason and date): _____ ❑ Client will:	
6. How is infant feeding going overall? _____ _____ How many times in 24 hours, day and night do you feed your baby: ____Breastmilk _____ Formula _____Water _____Juice _____Baby Foods _____Table foods _____Other, Describe:_____ Does your baby ever go more than three hours between feedings? ❑ No ❑ Yes ❑ Number wet diapers/day_____ ❑ Number dirty diapers/day_____ Using pacifier? ❑ Yes ❑ No Does baby take a supplement with vitamin D? ❑ Yes ❑ No (see guidance in care plan) Are you planning to return to work or school? ❑ No ❑ Yes, explain: If breastfeeding, are you having any of these concerns? ❑ Cracked, sore nipples ❑ Not enough milk ❑ Baby doesn't take breast easily What breastfeeding questions can we answer today?	Client goal/plan: follow STT N handouts: ❑ **A Guide to Breastfeeding** ❑ *Tips for Addressing Breastfeeding Concerns* ❑ *What to Expect while Breastfeeding: Birth to Six Weeks* ❑ **Breastfeeding Checklist for My Baby and Me** ❑ **Breastfeeding and Returning to Work or School** ❑ **Nutrition and Breastfeeding: Common Questions and Answers** ❑ **My Breastfeeding Resources** ❑ Plans to exclusively breastfeed for 6 months and after 6 months, plans to continue breastfeeding with the addition of solid foods ❑ Use local breastfeeding resources: _____ ❑ Referred to provider for Vitamin D supplement if exclusively breastfeeding or consuming less than 1 quart (32 oz.) of infant formula per day. ❑ Referred to (profession, reason and date):_____ ❑ Client will:	
7. Have you fasted while breastfeeding or do you plan to fast while breastfeeding? ❑ No ❑ Yes, describe:_____ _____ ❑ How often: ❑ How long:	❑ Client goal/plan: follow ❑ **Making Plenty of Milk** *and* ❑ **How to Know your Baby is Getting Plenty of Milk** *in* **What to Expect in the First Week of Breastfeeding** ❑ **You Can Pump and Store** ❑ Use local breastfeeding resources: ❑ Referred to RD (date):_____ ❑ Referral to (profession, reason and date): _____ _____ ❑ Client will:	
8. Do you have the following? ❑ Oven ❑ Electricity ❑ Microwave ❑ Stove ❑ Refrigerator ❑ Clean running water ❑ Missing any of the above	Client reviewed STT N handout(s): ❑ **Tips for Cooking and Storing Food** ❑ **When You Cannot Refrigerate, Choose These Foods** ❑ **Tips for Keeping Food Safe** ❑ Referred to RD (date): _____ ❑ Referred to (profession, reason and date): _____ _____ ❑ Client will:	

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Com-ment
9. Within the past 12 months, were you worried whether your food would run out before you or your family had money to buy more? ❑ No ❑ Yes, Explain: Within the past 12 months, were there times when the food that you or your family bought just did not last and you did not have money to get more? ❑ No ❑Yes, Explain: Do you use any of the following food resources? • WIC: ❑ No ❑Yes WIC Site: _____ • CalFresh (food stamps)? ❑Yes ❑ No • Have you used any other food resources, such as food banks, pantries or soup kitchen? ❑Yes ❑ No	Client reviewed STT N handout(s): ❑ **You Can Eat Healthy and Save Money: Tips For Food Shopping** ❑ **You Can Stretch Your Dollars: Choose These Easy Meals and Snacks** ❑ **You Can Buy Low-Cost Healthy Foods** ❑ Referred client to WIC ❑ Referred client to CalFresh (Food Stamps) ❑ Referred client to local emergency food resources ❑ Referred to RD (date): _____ ❑ Referred to (profession, reason and date):_____ ❑ Client will:	
10. What kinds of physical activity do you do?_____ How often?_____ How long?_____ On an average day, are you physically active at least 30 minutes each day? ❑ Yes ❑ No On an average day, do you spend over 2 hours watching TV or other screen? ❑ No ❑ Yes, explain: Has a doctor told you to limit your activity? ❑ No ❑ Yes If yes, Explain:	❑ Client identified ways to be more active each day ❑ Referred to (profession, reason and date): _____ ❑ Client will	
11. Complete Nutrition Assessment using one of these forms: ❑ 24-hour Perinatal Dietary Recall or ❑ Perinatal Food Group Recall or ❑ Approved Food Frequency Form	❑ Client identifies strengths and weaknesses demonstrated by nutrition assessment: _____ _____ Client agrees to follow STT N handout(s) (indicate date): ❑ **Choose Healthy Foods To Eat** ❑ **Vegetarian Eating** ❑ **Get The Iron You Need** ❑ **If You Need Iron Pills** ❑ **Iron Tips** ❑**Iron Tips: Take Two** ❑ **My Action Plan for Iron** ❑ **Get The Folic Acid You Need** ❑ **Get The Vitamin B_{12} You Need** ❑ **Food Rich in Calcium** ❑ **If you Had Diabetes While You Were Pregnant** ❑ **Now That Your Baby Is Here** ❑ **My Nutrition Plan for Moms**	
12. Other risk or dietary issue?	❑ Client goal/plan:	
13. Reviewed assessment with client and client identified the following strengths:		

Completed by:_____ _____ _____ **Nutrition minutes spent:** _____

Signature Title Date

Signature of MD if completed by CPHW_____