Postpartum Assessment
Instructions

This form is completed by the health services staff within two weeks of delivery. It is the responsibility of the social services staff to notify the health coordinator in advance to schedule the home visit. Once the visit takes place, a copy of the assessment is placed in the participant's file.

What Does the Two-Week Newborn Home Visit Address?

The first few weeks of a baby's life are an exciting and demanding time for the baby and the family. The two-week newborn visit required by the *Head Start Program Performance Standards* focuses on the "well-being of both the mother and the child."

This visit does not take the place of well-baby checks. It also does not replace medical care for the mother. Instead, at the two-week newborn visit, staff :

- supplement those medical appointments,
- address families' questions,
- evaluate the health of babies and mothers, and
- offer resources and referrals as necessary.

To the extent possible, staffs plan this visit with a family when the mother is pregnant. Staff describes the goals of the visit and document plans in the Family Partnership Agreement. Plans must stay flexible, however, as family preferences for the visit may change after the baby's birth.

Performance Standard:
1304.40(i)(6) Grantee and delegate agencies serving infants and toddlers must arrange for health staff to visit each newborn within two weeks after the infant's birth to ensure the well-being of both the mother and the child.

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division
Health Services Unit

Early Head Start Postpartum Assessment

Center/Facility Name: _____

Parent's name: _____

Infant's name: _____ Date of Birth: _____

Health Staff: _____ Date of visit: _____

1. How did labor and delivery go? *Explain:*

2. INFANT ASSESSMENT

Note each by using: {WNL} – within normal limits {ABN } – abnormal

_____ Overall appearance	_____ Mouth (sucking reflexes)	_____ Skin
_____ Respiration	_____ Trunk	_____ Umbilicus
_____ Eyes (clear)	_____ Extremities	_____ Nose (clear)

Has infant had a newborn check-up? ☐ Yes ☐ No If No, when scheduled?

Primary Care Provider and/or Medical Home:

Address:

If 'No', was a referral offered: ☐ Yes ☐ No Location:

3. GENITALIA ☐ Male ☐ Female Elimination:

4. FEEDING PATTERN

☐ Breast ☐ Formula ☐ Breast & Bottle How many ounces:

If formula, what type : How many times/day:

Are you enrolled with the WIC Program? ☐ Yes ☐ No If 'No', was referral offered? ☐ Yes ☐ No

Sleeping arrangements and patterns:

5. MOTHER'S HEALTH

Have you had your postpartum check -up? ☐ Yes ☐ No If No, when scheduled?

Any health problems since delivery? ☐ Yes ☐ No

If YES, please explain:

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HEALTH EDUCATION

If breast feeding: Do you have enough milk?	☐ Yes ☐ No	☐ N/A
Does your baby take the breast easily?	☐ Yes ☐ No	☐ N/A
Are your nipples cracked and/or sore?	☐ Yes ☐ No	☐ N/A
Do you have any questions about breast feeding?	☐ Yes ☐ No	☐ N/A
Do you have any questions about mixing or feeding formula?	☐ Yes ☐ No	☐ N/A
Do you have any questions about your baby's health? If 'Yes', please explain:	☐ Yes ☐ No	☐ N/A
Do you feel comfortable in your relationship with your baby? If 'Yes', please explain:	☐ Yes ☐ No	☐ N/A
Do you have any questions about your baby's safety? If 'Yes', please explain:	☐ Yes ☐ No	
Do you have the resources to assist in taking full benefit of the health of you and your baby?	☐ Yes ☐ No	
• If "No" indicate where needs exist: ☐ Housing ☐ Financial ☐ Food ☐ Family		
Has your relationship with the baby's father changed?	☐ Yes ☐ No ☐ N/A	
Are you using, or planning to use, any method of birth control?	☐ Yes ☐ No	
• If "Yes", which one?	If "No", would you like further information? ☐ Yes ☐ No	

REFERRALS:

☐ WIC Date Enrolled:	Agency:
☐ SNAP ☐ Medicaid ☐ AFDC ☐ Others:	Agency:

MATERIALS GIVENS:

☐ Birth Control ☐ Infant Feeding ☐ Infant Care ☐ Infant Safety	☐ OTHER:
☐ OTHER: ☐ OTHER:	☐ OTHER:

SIGNATURE

Health Services Staff:		Date:
Social Services Staff :		Date: