

HOSPITAL ENCOUNTER (ALL ENROLLEES)

Name: _____ Site: _____ Risk Status: _____

Risk factors previously identified: _____

Delivery Date: _____ Delivering Provider: _____ Birth Weight: _____ Sex: _____

Type of Delivery: _____ Induced: _____ Reason: _____ Anesthesia: _____

Complications: _____ NICU: Yes or No

Attended Childbirth Classes: Yes or No

Current Tobacco status: (N/A, No Chg, Reduced, Quit) If Smoking-Danger Discussed: _____

Smoking Cessation/Referral to Quitline: _____

Dangers of second hand smoke discussed: _____

Current Alcohol status: (N/A, No Chg, Reduced, Quit) If Using-Danger Discussed: _____ Referral: _____

Current Drug status: (N/A, No Chg, Reduced, Quit) If Using-Danger Discussed: _____ Referral: _____

Breastfeeding encouraged: _____ Mother breastfeeding: _____

Need to contact Medicaid worker/applying for Medicaid: _____

Pediatric provider chosen: _____ Patient 1st Newborn Assignment Form completed during pregnancy: _____

Importance of immunization/check-ups discussed: _____

Smile Alabama: _____

Infant danger signs/medical care in emergency discussed: _____

Safe Sleeping Methods Discussed: _____

Postpartum Depression signs and symptoms reviewed: _____

Postpartum appointment: _____/_____/_____ Importance of postpartum appointment: _____

Barriers to postpartum care identified (i.e. transportation): _____

Birth control method received in hospital: _____ Date received: _____

Birth control method desired: _____ Family planning method discussed with DHCP: _____

Family planning/Plan 1st services available: _____

Other needs identified during encounter/referrals: _____

Risk status: _____

CC Name: _____ Date: _____