Head Start
MID-AMERICA REGIONAL COUNCIL

MARC Head Start

Checking in with Mom and Baby

2 Week Post-partum Home Visit

Purpose of Visit

The 2-week post-partum home visit centers on the well-being of both mother and baby, focusing on support and identifying family needs.

Head Start
MID-AMERICA REGIONAL COUNCIL

Checking in with Mom and Baby: The 2 Week Post-Partum Home Visit

Date: ___________ **Time:** ___________ **EHS Home Visitor:** ________________________________

Mother's Name: ____________________________________ **Address:** ____

Baby's Name: ____________________________________ **DOB:** ____________ **Age today:** _______________

Checking on Baby	Checking on Mother
Birth Weight: ____ lbs ____ oz. Length: ____ in. Head circumference: ____in or _____ cm. Apgar Scores: 1 min _____ 5 min _____ Complications at Birth: Y N. If yes : Describe: ____ If male: Circumcised: Y N Concerns: ____ Umbilical cord still attached: Y N Concerns ____ Heb B #1 in hospital: Y N Passed Newborn Hearing Screen Y N	1. Weeks of gestation at 1st Pre Natal Care visit :__________ Prenatal complications: Y N If yes, what? ____ Weeks of gestation at time of Delivery? ____________________ Gravida_________ Parity: __________ Date and place of delivery: ____ Type of delivery: Vaginal ____ C Section ____ Number of Days in hospital ______ Problems during/after delivery:______________________________________ ____ ____ Date of next postpartum doctor's visit: _______________________________
II. Breastfeeding: go to next section if not BF. Mother is breastfeeding comfortably. Y N Sore Nipples: Y N Engorgement Y N Mother is nursing at least every 2.5 to 3 hours during the day and once at night. Y N Supplemental formula Y N If Yes, when and how much? ______________________________________ III. Bottle Feeding : Name of Formula: ___________________ How many feedings in a day? (24 hours) _____ How many ounces at a time? Spitting up: Y N Gassy: Y N	2. Nutrition Status: How is your appetite? ____ ____ Are you taking Vitamin/mineral supplements? Y N Drinking plenty of fluid: Water_____ Juice______ Other? ____________ Do you have adequate food on hand? Are you receiving WIC? Y N 3. Contraception Current method: ___________________ Planned method: ___________________ Plans for Spacing Children: ____

Concerns: ______________________________ ____	Concerns: ____
IV. Elimination: Number of wet diapers a day (24 hrs) ______ Number of soiled diapers a day((24 hours) _____	4. Elimination: Voiding/bowel function concerns? ___________________________________ ____.
V. General well- being: How would you describe your baby? ____ ____. My baby is sleeping well. Y N My baby is eating, sucking well. Y N My baby can hear sounds. Y N My baby looks at my face. Y N My baby quiets to my voice, touch being held or swaddled. Y N Demonstrate, if needed, how to interact with infant: 1. Establish eye contact 2. Hold closely, touch and stroke and rock 3. Talk and sing to baby Point out to mother the unique characteristics of her baby.	5. General well-being: How are you feeling? ___________________________________ How do you feel the delivery went? Did things go as you expected? ____ ____ ____ Emotional status* Feelings regarding motherhood: What's it like being a 'mom'? ____ ____ How well do you think your needs are being met: ____ ____ Who are your Support persons? ____ ____ Have you experienced any of these feelings? Happy: Y N Unhappy / Sad: Y N Excited: Y N Overwhelmed: Y N Sleeping Well: Y N Unable to sleep: Y N Thoughts of Harm to Yourself: Y N To the baby: Y N Fatigue that prevents you from caring for baby or yourself? Y N Comments: ____
VI. Observation, discussion, resources: Crib: Back to Sleep; Safety : No blankets/Stuffys Car Seat: Safety: Positioning…right size..	6.Observation and discussion: 1. Observe feeding and caring for infant: + -

Feeding: No bottle propping ; Positioning Shaken Baby Syndrome : Time Out for Parents Baby's doctor: ___________________________ Next Appointment: ________________________ Enrolled in EHS: Y N Use Portrait of a Healthy Child to set goals for getting baby and mom to 2 month Check - ups.	2. Ask mother if family members assist her in caring for infant? Who? ____ ____ 3. Ask about source of income and its adequacy for meeting the basic family needs for food, shelter and clothing. ____ ____
Next Steps: Resources needed: Postpartum/family planning: Y N Parenting classes: Y N Transportation: Y N Medicaid Waiver for FP Services: Y N Breastfeeding support: Y N	7. Type of dwelling/condition: + - Cleanliness + - Number living in home: Adults:____ Children: ___ Do you have a working: Stove ___ Refrigerator ___Water ___ Plumbing ___ and Electricity ____. Smoking: Home Y N Car Y N Smoke Detector: Y N Carbon Monoxide Detector: Y N