The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Patient Addressograph

POSTPARTUM CARE PLAN

To be developed prenatally by the patient and her maternity provider and revised as needed after delivery.

Name:
LAST FIRST MIDDLE

Care Team

Primary Maternal Provider/Group:	Care Coordinator:
	Home Visitor:
PCP:	MFM:
Infant Medical Provider:	Consultant:
Lactation Support:	Consultant:

Postpartum Visits

Early Visit (Indication) _____ /_____ /_____ At: _____

☐ Hypertension ☐ Depression/Anxiety ☐ Wound Check ☐ Lactation Difficulties ☐ Medication Titration ☐ Other: _____

Comprehensive Visit _____ /_____ /_____ At: _____

Reproductive Life Plan

Number Of Children Desired:	Timing Of Next Pregnancy:

Contraceptive Plan

☐ BTL ☐ Implant ☐ LNG-IUS ☐ Copper IUD ☐ Depot Medroxyprogesterone Acetate (DMPA) ☐ Combined Ocp ☐ Progesterone Only Pill

☐ Vasectomy ☐ Condoms ☐ Diaphragm ☐ Lactational Amenorrhea ☐ Natural Family Planning ☐ Other

Immediate Postpartum LARC?

☐ Desires ☐ Declines ☐ Unsure

Infant Feeding Plan

☐ Exclusive Breastfeeding For _____ Months ☐ Mixed Feeding ☐ Formula

Community Resources

☐ WIC Peer Counselor ☐ Mothers' Groups ☐ Lactation Warmline ☐ Return To Work Resources

Pregnancy Complications

Complication_____	**Follow-Up Scheduled**	**Result**
☐ GDM	Glucose Screen: _____ /_____ /_____	_____ MG/DL (Fasting) _____ MG/DL (Post 75 G Load)
☐ Preeclampsia ☐ GHTN	BP Check _____ /_____ /_____	_____ /_____ MM HG
☐ Other:		

Mental Health

Risk For Postpartum Depression/Anxiety	**Screening (Should Be Performed At Least Once During Perinatal Period)**
☐ High ☐ Medium ☐ Low	Date: _____ /_____ /_____ Result:

Postpartum Problems

☐ Perineal/C-Section Wound Pain ☐ Urinary Incontinence ☐ Fecal Incontinence ☐ Dyspareunia/Reduced Sexual Desire ☐ Fatigue/Sleep Issues

Referrals/Interventions:

Chronic Health Conditions

Problem	**Plan**
1.	
2.	
3.	
4.	

Patient Addressograph

POSTPARTUM FORM

Name:
LAST FIRST MIDDLE

ID#: EDD:

Discharge Date: -- --

Delivery Information

Delivery At_____weeks

☐ Vaginal ☐ Cesarean
☐ Svd ☐ Primary (For:_____)
☐ Vacuum ☐ Repeat (For:_____)
☐ Forceps
☐ Episiotomy ☐ Uterine Incision
☐ Lacerations ☐ Low Transverse
☐ Tolac ☐ Low Vertical
☐ Classical

Labor

☐ None
☐ Spontaneous
☐ Induced
☐ Augmented

Anesthesia

☐ None
☐ Local/Pudendal
☐ Epidural
☐ Spinal
☐ General
☐ Other:

Postpartum Contraception

BTL	☐ Yes	☐ No
Implant	☐ Yes	☐ No
LNG-IUS	☐ Yes	☐ No
Copper IUD	☐ Yes	☐ No
Depot Medroxyprogesterone Acetate (DMPA)	☐ Yes	☐ No
Combined OCP	☐ Yes	☐ No
Progesterone-Only Pill	☐ Yes	☐ No
Vasectomy	☐ Yes	☐ No
Condoms	☐ Yes	☐ No
Diaphragm	☐ Yes	☐ No
Lactational Amenorrhea	☐ Yes	☐ No
Natural Family Planning	☐ Yes	☐ No

Other: _____

Delivered By: _____

Postpartum Information

Complications

☐ None ☐ Hemorrhage ☐ Infection ☐ Hypertension ☐ Diabetes ☐ Other: _____

Discharge Information

Neonatal Information

Name Of Baby: _____

Sex
☐ Female ☐ Male
Circumcision ☐ Yes ☐ No

Birth Weight: _____ g

Disposition
☐ Home With Mother ☐ In Hospital
☐ Transfer ☐ Neonatal Death
☐ Stillbirth ☐ Other:_____

Complications/Anomalies:

Newborn Care Provider:

Seen By Newborn Care Provider Before Discharge
☐ Yes ☐ No

Received Hepatitis B Birth Dose Prior to Hospital Discharge ☐ Yes ☐ No

Maternal Information

Maternal Age:_____ Gravity And Parity:_____

Regarding Smoking, Chewing, Using A Nicotine Delivery System (ENDS), and Vaping
☐ Does Not Use ☐ Quit During Pregnancy
☐ Current User

HGB/HCT Level: _____

Medications: _____

HIV Status* Known ☐ Yes ☐ No
☐ POS
☐ NEG

Feeding Method ☐ Breast ☐ Bottle

Diagnostic Studies Pending:

Secondary Diagnosis/Preexisting Conditions
☐ Asthma ☐ Hypertension
☐ Diabetes ☐ Other: _____

Immunizations Given
☐ Anti-D Immune Globulin
☐ Tdap Or TD ☐ HPV (When Indicated)
☐ No, Received During Pregnancy
☐ No, Received Before Pregnancy
☐ Patient Declined

☐ Influenza ☐ Varicella
☐ No, Received During Pregnancy ☐ Other:_____
☐ Patient Declined
☐ MMR (When Indicated)

Infant Status: _____

☐ If Neonatal Death, Bereavement Counseling

Follow-Up Appt: _____

Date: ____/____/____

Location: _____

Other: _____

*Check state requirements before recording results.

Interim Contacts Or Hospitalizations

Date	Comment

PROVIDER SIGNATURE (AS REQUIRED): _____

(AA197) 12345/54321

Postpartum Visit

Date: – –

Feeding Method:

Contraception Method

- Tubal Sterilization ☐ Yes ☐ No
- Intrauterine Device (IUD) ☐ Yes ☐ No
- Depot Medroxyprogesterone Acetate (DMPA) ☐ Yes ☐ No
- Implant ☐ Yes ☐ No
- Oral Contraceptives ☐ Yes ☐ No
- Other: _____

Postpartum Depression Screening:

Intimate Partner Violence Screening:

Discuss Tobacco (Smoked, Chewed, ENDS, Vaped) Relapse Prevention Techniques:

Infant Health:

Interim History:

Follow-Up Lab Studies Ordered

☐ Yes ☐ No Postpartum HCB/HCT: _____

☐ Yes ☐ No Postpartum Glucose Screening If Patient Had Gestational Diabetes: _____

☐ Yes ☐ No Other Studies Requested: _____

Physical Examination

BP:_____ WT:_____ BMI:_____

Breasts	☐ Normal	☐ Abnormal:	_____
Abdomen	☐ Normal	☐ Abnormal:	_____
External Genitalia	☐ Normal	☐ Abnormal:	_____
Vagina	☐ Normal	☐ Abnormal:	_____
Cervix	☐ Normal	☐ Abnormal:	_____
Uterus	☐ Normal	☐ Abnormal:	_____
Adnexa	☐ Normal	☐ Abnormal:	_____
Rectal–Vaginal	☐ Normal	☐ Abnormal:	_____

Pap Test ☐ Yes ☐ No If No, Due: _____

Allergies:

Immunization Update:

Medications/Contraception:

☐ Dispensed

Interval Care Recommendations

For General Health Promotion:

Plans For Future Pregnancies:

For Reproductive Health Promotion:

Repeat Glucose Screening Needed? ☐ Yes ☐ No
If Yes, Has Patient Been Counseled? ☐ Yes ☐ No
Date Of Repeat Testing:

Return Visit:

Referrals:

Examined By:

Comments

PROVIDER SIGNATURE (AS REQUIRED): _____