Community Postpartum Record

(See Guidelines for Completing Postpartum Record)

COMPLETE OR AFFIX LABEL:

Last Name | First Name

Community

DOB DD / MM / YYYY

Nunavut Health #

Phone # | House #

BIRTH HISTORY

Date of Birth: DD / MM / YYYY

Place of Birth:

Date Returned Home: DD / MM / YYYY

Review of Birth: ☐ **Vaginal** ☐ Spontaneous ☐ Forceps ☐ Vacuum ☐ VBAC ☐ **C-Section** ☐ Planned ☐ Unplanned

GA at Birth:

Birth Complications (if any):

☐ Kept baby ☐ Adopted (Name of guardian) ☐ Other (explain)

Other children/ages:

Comments

1st PP Visit within 2 weeks of birth	*2nd PP Visit at 1 month after birth*	*3rd PP Visit at 6 weeks (family planning)*
Date: DD / MM / YYYY Type of Visit: Health Centre/Home	Date: DD / MM / YYYY	Date: DD / MM / YYYY

MATERNAL PHYSIOLOGICAL HEALTH ASSESSMENT

Vital Signs (assess at 1st visit)	T	BP	P	RR	0^2 Sat	Wt (kg):

Current medications (assess at 1st visit)

Assess at each visit (Indicate postpartum visit 1st, 2nd or 3rd and use Progress Notes for additional space)

General concerns

Rest and energy

Assess at each visit (Indicate 1st, 2nd or 3rd postpartum visit in assessment box)

Fundal Position	☐ Above Umbilicus	☐ At Umbilicus	☐ Below Umbilicus	☐ At Symphysis Pubis	☐ Other					
C/S Incision	☐ Not Applicable	☐ Clean and Dry	☐ Gapping	☐ Open (packed)	☐ Foul Discharge					
Lochia Amount	☐ Large	☐ Moderate	☐ Small	☐ Intermittent	☐ Nil	☐ Other				
Lochia Type	☐ Rubra	☐ Serosa	☐ Alba	☐ Clots	☐ Foul Odor					
Perineum - bottom	☐ Intact	☐ Laceration	☐ Episiotomy	☐ Painful	☐ Not Assessed	Hemorrhoids: ☐ Yes ☐ No				
Bowel function	**1st Visit** ☐ No Concerns	☐ Constipated	**2nd Visit** ☐ No Concerns	☐ Constipated	**3rd Visit** ☐ No Concerns	☐ Constipated				
Family planning	☐ Access to acceptable birth control	☐ Teaching provided	☐ Six week visit scheduled							
Breasts	☐ Soft	☐ Filling	☐ Full	☐ Engorged	☐ Painful	☐ Plugged duct(s)	☐ Mastitis			
Nipple Left	☐ Normal	☐ Bleeding	☐ Cracked	☐ Flat	☐ Inverted	☐ Tender	☐ Yeast	☐ Other		
Nipple Right	☐ Normal	☐ Bleeding	☐ Cracked	☐ Flat	☐ Inverted	☐ Tender	☐ Yeast	☐ Other		

MATERNAL PSYCHOSOCIAL HEALTH ASSESSMENT

Assess at each visit (Indicate postpartum visit 1st, 2nd or 3rd and use Progress Notes for additional space)

Adjustment/coping			
Responds to infant cues	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Family supportive	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Family conflict	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychosocial concerns *If concerns identified refer to supports.*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Edinburgh PP Depression Scale score at 1 month visit: _____

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NEWBORN FEEDING *(Assess Newborn Using the Well Child Record)*

	1st postpartum visit	2nd postpartum visit
Feeding type	☐ Breast ☐ Bottle ☐ Both ☐ Other:	☐ Breast ☐ Bottle ☐ Both ☐ Other:
If breastfeeding:	Assess at first visit:	
Position/ Latch Effective	☐ Yes ☐ No ☐ Comments:	☐ Yes ☐ No ☐ Comments:
Milk Transfer Identified	☐ Yes ☐ No ☐ Comments:	☐ Yes ☐ No ☐ Comments:
If bottlefeeding:	**1st postpartum visit**	**2nd postpartum visit**
Milk in bottle	☐ I-F Formula ☐ EBM ☐ Other:	☐ I-F Formula ☐ EBM ☐ Other:

Chart comments or concerns on infant feeding in Well Child Record and indicate in Maternal Progress Note

SELF-CARE *(Infant-care topics in Well Child Record)* ✓ if discussed and no concerns, ✗ if concerns and chart in Progress Notes

☐ Activity/rest ☐ Nutrition ☐ Iron/Vitamins ☐ Pericare/comfort measures ☐ Kegels ☐ Bowels/bladder

☐ S&S infection (breast/incision) ☐ S&S DVT/Pulm Emb ☐ Resuming sexual activity ☐ PPD ☐ Relationship safety

☐ Tobacco ☐ Alcohol, Marijuana/other drugs ☐ When to Call Health Centre for self or baby

MATERNAL BLOODWORK/SCREENING/OTHER - SEE PRENATAL RECORD:

RH Factor (check if required and give **at first visit**)	Required: ☐ Yes ☐ No If required date given: DD / MM / YYYY	*If Rhig/WinRho given wait 3 months before giving varicella or rubella immunization (if required).*
Blood work/immunizations at one month visit or at six weeks if not completed at one month:		
CBC (if Hx or Sx) of anemia	Date: DD / MM / YYYY	Result:
TSH (if Hx or Sx)	Date: DD / MM / YYYY	Result:
GC/Chlamydia (if applic)	Date: DD / MM / YYYY	Result:
Trich & BV swabs (if Sx)	Date: DD / MM / YYYY	Result:
Rubella Imm (if required)	Required: ☐ Yes ☐ No	If required date given: DD / MM / YYYY
Varicella Imm (if required)	Required: ☐ Yes ☐ No	If required date given: DD / MM / YYYY
At six week visit:		
PAP Test (according to GL)	Indicated by GL: ☐ Yes ☐ No	If Yes, Pap Test done: ☐ Yes ☐ No
Family planning	Method selected and provided/planned:	
75 gm OGTT (if Hx GDM)	Date: DD / MM / YYYY	Result:

Signature & Designation:	1st visit	2nd visit	3rd visit

REFERRALS: *(chart referral and outcome in Progress Notes)*

☐ OB/GYN/RM	Date: DD / MM / YYYY	Comment:	Initial:
☐ Mental Health	Date: DD / MM / YYYY	Comment:	Initial:
☐ RD/PHN/other	Date: DD / MM / YYYY	Comment:	Initial:

COMMENTS/PLAN:

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EDINBURGH PERINATAL/POSTNATAL DEPRESSION SCALE (EPDS) SCORING GUIDE

Ask questions at 1 month visit and score as below.

1. I have been able to laugh and see the funny side of things
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than I used to
   - 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. I have been anxious or worried for no good reason
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

5. I have felt scared or panicky for no very good reason
   - 3 Yes, quite a lot
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

6. Things have been getting on top of me
   - 3 Yes, most of the time I haven't been able to cope
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped quite well
   - 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all

8. I have felt sad or miserable
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all

9. I have been so unhappy that I have been crying
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never

10. The thought of harming myself has occurred to me
    - 3 Yes, quite often
    - 2 Sometimes
    - 1 Hardly ever
    - 0 Never

TOTAL ☐

EPDS SCORE	INTERPRETATION	ACTION
Less than 8	Depression not likely	Continue support
9 – 11	Depression possible	Support, re-screen in 2–4 weeks. Consider referral to primary care provider (PCP).
12 – 13	Fairly high possibility of depression	Monitor, support and offer education. Refer to PCP.
14 and higher (positive screen)	Probable depression	Diagnostic assessment and treatment by PCP and/or specialist.
Positive score (1, 2 or 3) on question 10 (suicidality risk)		Immediate discussion required. Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby.

References:

Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry.* 1987; 150(6):782-786.

BC Reproductive Mental Health Program and Perinatal Services BC. (2014), *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period*. Available at: http://tiny.cc/MHGuidelines