

PATIENT (MOTHER AND INFANT) INFORMATION

<i>Patient (Mother) Name</i>		<i>Patient DOB</i>	<i>Patient Medicaid #</i>
<i>Prenatal Care Site or Physician</i>		<i>Delivering MD</i>	<i>County of Residence</i>
<i>Delivering Hospital:</i>	<i>Admit Date</i>	<i>Delivery Date</i>	<i>Discharge Date</i>
Pregnancy Outcome: <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal Demise <input type="checkbox"/> Neonatal Demise			
Gestational Age at Delivery: _____ + _____ <small>Weeks Days</small>		Infant Del. Wt: _____ _____ <small>lbs. oz.</small>	
Infant Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Infant admitted to: <input type="checkbox"/> NICU <input type="checkbox"/> Well Baby Nursery	
Type of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> VBAC <input type="checkbox"/> Repeat C-S <input type="checkbox"/> AVBAC			
Type of Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Regional <input type="checkbox"/> Local <input type="checkbox"/> Narcotics <input type="checkbox"/> None <input type="checkbox"/> Other, List: _____			
Induced: <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: <input type="checkbox"/> PROM <input type="checkbox"/> Fetal Distress <input type="checkbox"/> Toxemia <input type="checkbox"/> Elective <input type="checkbox"/> Other			
Medical risks and delivery complications: _____			

(District #12 (Gift of Life) Counties: Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, and Washington)

PATIENT ENCOUNTER INFORMATION

Current Tobacco status: (No Chg / Reduced / Quit / NA) **Danger Discussed:** _____

Smoking Cessation / Referral to the Quitline 1-800-QUITNOW: _____

Dangers of second-hand smoke discussed: _____

Current alcohol status: (No Chg / Reduced / Quit / NA) **Danger Discussed:** _____ **Referral:** _____

Current drug status: (No Chg / Reduced / Quit / NA) **Danger Discussed:** _____ **Referral:** _____

Breastfeeding: Yes No **Encouraged:** _____

Need to contact Medicaid worker / Notify Medicaid of birth: _____

Pediatric provider: _____ **Patient 1st Newborn Assignment form completed:** Yes No

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: _____

Importance of postpartum appointment: _____ **Date, if known:** ____ / ____ / ____ **With whom:** _____

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

Birth control: Discussed: _____ **Method desired:** _____ **Method given:** _____

Family Planning / Plan 1st services available: _____

Other needs identified during encounter/referrals: _____