

**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>
<b>Pregnancy Outcome:</b> <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal Demise <input type="checkbox"/> Neonatal Demise			
<b>Gestational Age at Delivery:</b> _____ + _____ <small>Weeks                                  Days</small>		<b>Infant Del. Wt:</b> _____    _____ <small>lbs.                                  oz.</small>	
<b>Apgars:</b> _____    _____ <small>                                1 min.                          5 min.</small>			
<b>Infant Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Infant admitted to:</b> <input type="checkbox"/> NICU <input type="checkbox"/> Well Baby Nursery	
<b>Type of Delivery:</b> <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> VBAC <input type="checkbox"/> Repeat C-S <input type="checkbox"/> AVBAC			
<b>Type of Anesthesia:</b> <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: _____			
<b>Induced:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Reason:</b> <input type="checkbox"/> PROM <input type="checkbox"/> Fetal Distress <input type="checkbox"/> Toxemia <input type="checkbox"/> Elective <input type="checkbox"/> Other			
<b>Medical risks and delivery complications:</b> _____			

(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:** \_\_\_\_\_