



Gift of Life  
Maternity Care Program

# HOSPITAL ENCOUNTER (ALL ENROLLEES)

Name: \_\_\_\_\_ Site: \_\_\_\_\_ Risk Status: \_\_\_\_\_

Risk factors previously identified: \_\_\_\_\_

Delivery Date: \_\_\_\_\_ Delivering Provider: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Type of Delivery: \_\_\_\_\_ Induced: \_\_\_\_\_ Reason: \_\_\_\_\_ Anesthesia: \_\_\_\_\_

Complications: \_\_\_\_\_ NICU: Yes or No

Attended Childbirth Classes: Yes or No

Current Tobacco status: (N/A, No Chg, Reduced, Quit) If Smoking-Danger Discussed: \_\_\_\_\_

Smoking Cessation/Referral to Quitline: \_\_\_\_\_

Dangers of second hand smoke discussed: \_\_\_\_\_

Current Alcohol status: (N/A, No Chg, Reduced, Quit) If Using-Danger Discussed: \_\_\_\_\_ Referral: \_\_\_\_\_

Current Drug status: (N/A, No Chg, Reduced, Quit) If Using-Danger Discussed: \_\_\_\_\_ Referral: \_\_\_\_\_

Breastfeeding encouraged: \_\_\_\_\_ Mother breastfeeding: \_\_\_\_\_

Need to contact Medicaid worker/applying for Medicaid: \_\_\_\_\_

Pediatric provider chosen: \_\_\_\_\_ Patient 1<sup>st</sup> Newborn Assignment Form completed during pregnancy: \_\_\_\_\_

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: \_\_\_\_\_

Postpartum appointment: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Importance of postpartum appointment: \_\_\_\_\_

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

Birth control method received in hospital: \_\_\_\_\_ Date received: \_\_\_\_\_

Birth control method desired: \_\_\_\_\_ Family planning method discussed with DHCP: \_\_\_\_\_

Family planning/Plan 1<sup>st</sup> services available: \_\_\_\_\_

Other needs identified during encounter/referrals: \_\_\_\_\_

\_\_\_\_\_

Risk status: \_\_\_\_\_

CC Name: \_\_\_\_\_ Date: \_\_\_\_\_