TWO WEEK POSTPARTUM AND NEWBORN VISIT SUMMARY

Mother Name: _____ **Date:** _____

Newborn Name: _____ **Date of Birth:** _____

Birth Weight: _____ **Birth Length:** _____ **Date of Next Doctor Appt:** _____

MATERNAL HEALTH AND WELLBEING
Please share your birthing story. *(Length of labor, vaginal/cesarean birth, complications, celebrations, etc.)*
Who do you have to support you? *(What does that support look like?)*
How much rest are you getting? *(Guidance: important to rest when baby sleeping, if there is help available, please take it.)*
Please share about your activity and energy levels.
What are you typically eating and drinking each day? *(Guidance: important to eat 3 meals plus 1-2 snacks and drink plenty of fluids each day—especially when breastfeeding. Review WIC, SNAP enrollment and refer to nutritionist if applicable.)*
Do you have any concerns about your physical recovery? *(Bleeding, pain, incision healing, etc. Guidance: if there are concerns, refer to mother's doctor, remind about ability to go prior to 6 weeks if have concerns—offer to help call if needed.)*
Do you have any concerns about your emotional recovery? *(Guidance: if mother has any concerns about postpartum recovery and/or emotional wellbeing, encourage her to call primary health provider—offer to help call if needed.)*
Have you scheduled your 6-week postpartum appointment with your primary health provider? ☐ Yes ☐ No *Guidance: ask about any pain, return to exercise and sex, emotional wellbeing, breastfeeding, etc.* **Scheduled Date of Appointment:** _____
Is there anything else you would like to share?

TWO WEEK POSTPARTUM AND NEWBORN VISIT SUMMARY

NEWBORN HEALTH AND WELLBEING

What is the best thing about your new baby?

What is the most challenging part of having a newborn?

How are you feeding baby? ☐ Breastfeeding only ☐ Formula feeding only ☐ Combination of both

If exclusively BREASTFEEDING: **How often?** _____ **How long per breast?** _____

Pumping? ☐ Yes ☐ No **When do you pump?** _____

Any difficulties with breastfeeding? *(Sore nipples, engorgement, poor latch/suck, low/excessive milk production, etc.)*
(Guidance: provide breastfeeding resources and refer for lactation support as needed)

If supplementing with formula: **How often?** _____ **How many ounces?** _____

If exclusively FORMULA FEEDING: **How often?** _____ **How many ounces per feeding?** _____

How many times a day? _____ **How many ounces?** _____

(Guidance: Regardless of how baby is being fed, it is important for newborns to be fed on demand. Provide resources about hunger and satiation cues as needed. Offer guidance about how formula is provided.)

How do you position your baby for feeding? *(Guidance: Provide information regarding positioning, bottle propping, etc. as needed.)*

About how many diapers do you change in a day? Wet only: _____ Stool: _____

(Guidance: Diapers should be changed at least 6-10 times in a 24-hour period. If baby sometimes goes multiple hours with a dry diaper, encourage contacting the doctor.)

Please share about how your baby is sleeping. *(Hours of sleep, sleep position, type of bedding, location, etc.)*
(Guidance: review safe sleep practices and provide resources as needed.)

How long does your baby stay awake at a time? _____
What is your baby doing while awake? _____

Has your baby been to the doctor yet? ☐ Yes ☐ No **Date of Appointment?** _____
What happened at the visit? _____

What is the date of your baby's next Well Child Exam? _____
(Guidance: If baby has not yet be seen by a healthcare provider and/or does not have an appointment scheduled, encourage parents to make one as soon as possible and help make call if needed.)

How often do you clean your baby's gums? _____
(Guidance: Share importance of early oral care, including transfer of oral bacteria from adult to baby on pacifiers, bottle nipples, etc. and provide resources as needed.)

Do you have any concerns about your baby's care or general health?

List any resources or referrals provided to family:

Staff Completing Form: _____ **Date:** _____