# Discharge/Postpartum Form

**Delivery Date** _____________  **Hospital** _____________

**Discharge Date** _____________

## Delivery Information

<table>
<thead>
<tr>
<th>Delivery at ___________ Weeks</th>
<th>Vaginal</th>
<th>Cesarean</th>
<th>Tubal Sterilization</th>
<th>Notes</th>
<th>Labor</th>
<th>Anesthesia</th>
</tr>
</thead>
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</tbody>
</table>

**Labor**
- None
- Spontaneous
- Induced
- Augmented
- Local/Pudendal
- Epidural
- Spinal
- General
- Other

**Anesthesia**
- None
- Spontaneous
- Induced
- Augmented
- Local/Pudendal
- Epidural
- Spinal
- General
- Other

**Delivered By**  

## Complications

- None
- Hemorrhage
- Infection
- Hypertension
- Other

## Postpartum Information

## Discharge Information

**Name of Baby**  

**Sex**
- Female
- Male

**Birth Weight**  

**Disposition**
- Home with Mother
- In Hospital
- Other

**Complications/Ailments**

**Pediatrician**

**Immunizations Given**
- Anti-D Immune Globulin
- Rubella
- Other

**Follow-Up Appt**
- Date  
- Location  
- Other

## Maternal Information

**Height Level**

**Medications**

**Feeding Method**
- Breast
- Bottle

**Contraceptive Method (If Applicable)**

**Secondary Diagnosis/Preexisting Conditions**
- Asthma
- Hypertension
- Diabetes
- Other

## Interpret Contacts

**Date**  

**Comment**
**POSTPARTUM VISIT**

<table>
<thead>
<tr>
<th>Date</th>
<th>Lab Studies Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td>Last Pap Test</td>
</tr>
<tr>
<td>Feeding Method</td>
<td>Contraceptive Method</td>
</tr>
<tr>
<td>Postpartum Depression Screening</td>
<td>Intimate Partner Violence Screening</td>
</tr>
<tr>
<td>Interim History</td>
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</tbody>
</table>

**Physical Exam**

<table>
<thead>
<tr>
<th>BP</th>
<th>WT</th>
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</thead>
<tbody>
<tr>
<td>Breasts</td>
<td>Normal</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
</tr>
<tr>
<td>External Genitals</td>
<td>Normal</td>
</tr>
<tr>
<td>Vagina</td>
<td>Normal</td>
</tr>
<tr>
<td>Cervix</td>
<td>Normal</td>
</tr>
<tr>
<td>Uterus</td>
<td>Normal</td>
</tr>
<tr>
<td>Adnexa</td>
<td>Normal</td>
</tr>
<tr>
<td>Rectal</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Pap Test</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Comment**

**Allergies**

**Medications/Contraception**

- Dispensed

**Interval Care Recommendations**

- For General Health Promotion

- For Reproductive Health Promotion

**Return Visit**

**References**

**Examined By**

**Provider Signature (as Required)**

**Sample**