Patient Addressograph

DISCHARGE/POSTPARTUM FORM

DELIVERY DATE ______________ HOSPITAL ______________

DISCHARGE DATE ______________

DELIVERY INFORMATION

DELIVERY AT______WEEKS

☐ VAGINAL
- ☐ SVD
- ☐ VACUUM
- ☐ FORCEPS
- ☐ EPISIOTOMY
- ☐ LACERATIONS
- ☐ VBAC

☐ CESAREAN
- ☐ PRIMARY (For__________)
- ☐ REPEAT - ELECTIVE
- ☐ REPEAT - UNSUCCESSFUL VBAC

☐ INCISION
- ☐ LOW TRANSVERSE
- ☐ LOW VERTICAL
- ☐ CLASSICAL

TUBAL STERILIZATION ☐ YES ☐ NO

NOTES ______________

DELIVERED BY______________

LABOR
- ☐ NONE
- ☐ SPONTANEOUS
- ☐ INDUCED
- ☐ AUGMENTED

ANESTHESIA
- ☐ NONE
- ☐ LOCAL/PUDENDAL
- ☐ EPIDURAL
- ☐ SPINAL
- ☐ GENERAL
- ☐ OTHER

POSTPARTUM INFORMATION

COMPLICATIONS

☐ NONE ☐ HEMORRHAGE ☐ INFECTION ☐ HYPERTENSION ☐ OTHER ______________

DISCHARGE INFORMATION

NEONATAL INFORMATION

NAME OF BABY ______________

SEX
- ☐ FEMALE ☐ MALE

CIRCUMCISION
- ☐ YES ☐ NO

BIRTH WEIGHT ______________

DISPOSITION
- ☐ HOME WITH MOTHER ☐ IN HOSPITAL
- ☐ TRANSFER ☐ NEONATAL DEATH
- ☐ STILLBIRTH ☐ OTHER

COMPLICATIONS/ANOMALIES ______________

PEDIATRICIAN ______________

MATERNAL INFORMATION

HGB/HCT LEVEL ______________

MEDICATIONS ______________

FEEDING METHOD ☐ BREAST ☐ BOTTLE

CONTRACEPTIVE METHOD (IF APPLICABLE) ______________

DIAGNOSTIC STUDIES PENDING ______________

SECONDARY DIAGNOSIS/PREEXISTING CONDITIONS
- ☐ ASTHMA ☐ HYPERTENSION
- ☐ DIABETES ☐ OTHER ______________

IMMUNIZATIONS GIVEN
- ☐ ANTI-D IMMUNE GLOBULIN
- ☐ RUBELLA
- ☐ OTHER ______________

FOLLOW-UP APPT
- DATE ______________
- LOCATION ______________
- OTHER ______________

INTERIM CONTACTS

DATE	COMMENT

PROVIDER SIGNATURE (AS REQUIRED)______________

SAMPLE

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POSTPARTUM VISIT

DATE ____________

LAB STUDIES REQUESTED ____________

HGB/HCT ____________ LAST PAP TEST ____________

FEEDING METHOD ____________

CONTRACEPTIVE METHOD ____________

POSTPARTUM DEPRESSION SCREENING ____________

INTIMATE PARTNER VIOLENCE SCREENING ____________

INTERIM HISTORY

____

PHYSICAL EXAM

BP ____________ WT ____________

BREASTS ☐ NORMAL ____________

ABDOMEN ☐ NORMAL ____________

EXTERNAL GENITALS ☐ NORMAL ____________

VAGINA ☐ NORMAL ____________

CERVIX ☐ NORMAL ____________

UTERUS ☐ NORMAL ____________

ADNEXA ☐ NORMAL ____________

RECTAL-VAGINAL ☐ NORMAL ____________

PAP TEST ☐ YES ☐ YES

ALLERGIES ____________

MEDICATIONS/CONTRACEPTION ____________

☐ DISPENSED

INTERVAL CARE RECOMMENDATIONS

FOR GENERAL HEALTH PROMOTION ____________

FOR REPRODUCTIVE HEALTH PROMOTION ____________

RETURN VISIT ____________

REFERRALS ____________

EXAMINED BY ____________

COMMENT

____

PROVIDER SIGNATURE (AS REQUIRED) ____________

SAMPLE