



Maternal Health Outcome Summary

Client ID: _____

Admission ID: _____

Client's name (first, middle, last) _____ Maiden name _____

Client alias _____ Alias Client ID _____

Birth date ____/____/____ Social Security # _____

Street address _____ Apt# _____ County _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Message phone _____ Message place _____ Message contact _____

Emergency contact _____ Phone _____ Relationship _____

Discharge date: ____/____/____

Were services terminated prior to delivery? yes no

If yes, reason:

- | | |
|---|--|
| <input type="checkbox"/> client moved out of area | <input type="checkbox"/> therapeutic abortion |
| <input type="checkbox"/> fetal death | <input type="checkbox"/> transferred to another contractor |
| <input type="checkbox"/> maternal death | <input type="checkbox"/> transferred to other care |
| <input type="checkbox"/> services refused | <input type="checkbox"/> unable to locate |
| <input type="checkbox"/> spontaneous abortion | <input type="checkbox"/> Other specify _____ |

Will client receive postpartum home visit? yes no

Date postpartum referral was sent: ____/____/____ Date of postpartum home visit completion: ____/____/____

Primary Payment Source: (enter option from payment source table below) _____

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> county funds | <input type="checkbox"/> Medicaid | <input type="checkbox"/> SSI | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> eligible/not receiving Title XIX | <input type="checkbox"/> OB indigent | <input type="checkbox"/> Title V | |
| <input type="checkbox"/> Hawk | <input type="checkbox"/> presumptive eligibility | <input type="checkbox"/> uninsured | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> private insurance | <input type="checkbox"/> unknown | |
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay/sliding scale | <input type="checkbox"/> non-billable | |

WIC certified? yes no unknown

Did client attend childbirth education classes? yes no unknown

Delivery date ____/____/____

Multiple birth? yes no How many births? _____

Complications with this pregnancy? yes no

Did mother begin breastfeeding? yes no unknown

Pregnancy Comments:

- Where delivered:
- | | | |
|--|---|--|
| <input type="checkbox"/> birthing center | <input type="checkbox"/> level I hospital | <input type="checkbox"/> U of I Hospital or Clinic |
| <input type="checkbox"/> clinic | <input type="checkbox"/> level II hospital | <input type="checkbox"/> unknown |
| <input type="checkbox"/> doctor's office | <input type="checkbox"/> level II regional hospital | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> home delivery | <input type="checkbox"/> level III perinatal center | |

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Child Information

	Child #1	Child #2 (twin)	Child #3 (triplet)
Child's name (first, middle, last)			
Gender	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female
Birthdate	___/___/___	___/___/___	___/___/___
Gestational age at birth (weeks)			
Outcome	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn
Type of delivery	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean
Birthweight (grams)			
Length			
ID ID Type			
Abnormalities or health problems	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Describe health problem			
Has child died?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Date of death	___/___/___	___/___/___	___/___/___

Add pages if necessary for multiple births

Does client smoke cigarettes? yes no unknown

How many cigarettes per day?

<input type="checkbox"/> <1	<input type="checkbox"/> 10-20	<input type="checkbox"/> more than 2 packs
<input type="checkbox"/> 1-5	<input type="checkbox"/> 1 pack	<input type="checkbox"/> unknown
<input type="checkbox"/> 5-10	<input type="checkbox"/> 1-2 packs	

Does client drink alcohol? yes no unknown

How often ? never less than 1 drink/week 2-6 drinks/week 1 drink/day more than 1 drink/day

Does client use illicit drugs? yes no unknown

What drugs ?

<input type="checkbox"/> cocaine	<input type="checkbox"/> heroin	<input type="checkbox"/> unknown
<input type="checkbox"/> crack	<input type="checkbox"/> marijuana	<input type="checkbox"/> other
<input type="checkbox"/> crank	<input type="checkbox"/> methamphetamine	specify _____

Has client been tested for HIV/AIDs? yes no unknown client declines

Were results positive? yes no unknown client declines

Does client have STDs or a history of STDs? yes no unknown client declines

What STDs?

<input type="checkbox"/> chlamydia	<input type="checkbox"/> hepatitis	<input type="checkbox"/> syphilis	<input type="checkbox"/> other specify _____
<input type="checkbox"/> cytomegalovirus	<input type="checkbox"/> herpes	<input type="checkbox"/> trichomonas	
<input type="checkbox"/> gonorrhoea	<input type="checkbox"/> HPV	<input type="checkbox"/> unknown	

Is client being treated for STDs? yes no unknown client declines

Is partner being treated for STDs? yes no unknown client declines

Is client a medical risk? yes no unknown

Is client a nutritional risk? yes no unknown

Is client a psychosocial risk? yes no unknown

