Postpartum Mother Encounter - Midwifery

Patient Label Here

Demographics: ☐Per patient label OR

Mother Family Name _____ Given Name _____

Maternal Date of Birth: dd / mmm / yyyy Chart Number : _____ Postal Code: _____

☐**No Fixed address** **Estimated date of Birth:** dd / mmm / yyyy

Postpartum Complication: □ None □ Late Postpartum Hemorrhage □ Uterine atony □ Fever □ Perineal hematoma □ Hysterectomy □Perineal infection □ Abdominal incision infection □ Urinary Tract Infection □ Amniotic Fluid Embolus □ Pulmonary embolism □ Thrombophlebitis □ Mastitis □ Postpartum depression □ Other □ Unknown

Postpartum Breastfeeding Support: □ Provided assistance with breastfeeding within 6 hours of delivery after initial feeding
□ Consult with a lactation consultant □ Frequent skin to skin □ Hand expression/pumping □ Latch achieved prior to discharge
□ Referred mother to breastfeeding clinic, community health or peer support □Unknown □ Not applicable [includes stillbirth, adoption]

Healthy Baby Healthy Children (HBHC) Screen: √One □ Completed □ Completed and not sent to H.U. □ Not completed □ Unknown
If not completed Reason: □ Consent signed, but left hospital before completing □ Language barrier□ Midwifery care □ Mother refused □ Transferred to other hospital □ Unknown □ Other

Maternal Outcome: √One □Discharged home □Transfer to other hospital □Transfer to ICU/CCU □Transfer to other non-obstetrical unit same hospital □Maternal death-not related to pregnancy or birth □Maternal death-related to pregnancy or birth

If Maternal Death: Maternal death date: dd/mmm/yyyy Maternal death time: hours

If Transferred to ICU/CCU: Transfer date: dd/mmm/yyyy Transfer time: hours

Reason for transfer (if applicable): √One □ Lack of nursing coverage □ Lack of physician coverage □ Maternal medical/OBS problem □ No beds available □Organization evacuation □Birth outside of hospital prior to admission □ Keeping baby and mother together □ Care Closer to Home □ Condition Improved □ Other □ Unknown

If transferred to other hospital: Maternal Transfer Date: dd/mmm/yyyy Maternal Transfer Time: hours

If Discharged home: Maternal Discharge Date: dd/mmm/yyyy Maternal Discharge Time: hours

Maternal Transfer Back/Readmission Date: dd/mmm/yyyy Maternal Transfer Back/Readmission Time: hours

Maternal Outcome: √One □Discharged home □Transfer to other hospital □Transfer to ICU/CCU □Transfer to other non-obstetrical unit same hospital □Maternal death-not related to pregnancy or birth □Maternal death-related to pregnancy or birth

If Maternal Death: Maternal death date: dd/mmm/yyyy Maternal death time: hours

If Transferred to ICU/CCU: Transfer date: dd/mmm/yyyy Transfer time: hours Comments:

If transferred to other hospital: Maternal transfer to (hospital name):_____
Reason: √One □ Lack of nursing coverage □ Lack of physician coverage □ Maternal medical/OBS problem □ No beds available
□ Organization evacuation □ Birth outside of hospital prior to admission □ Keeping baby and mother together □ Care Closer to Home
□ Condition Improved □ Other □ Unknown

Midwifery Tab

Was care of the client transferred back to Midwifery during postpartum period? □yes □no □unknown

Was there maternal admission to hospital in postpartum: □yes □no □unknown	**Was there maternal postpartum transport to hospital:** □yes □no □unknown
Reason(s) for Transport: □ Postpartum hemorrhage □ repair of laceration □ other maternal clinical indication □ neonatal clinical indication □ **Did EMS attend during postpartum (not in the immediate postpartum)?** □ Yes □ No □ Unknown ***Barrier to Transport:*** □ None □ Delayed arrival time of EMS □ Delayed Departure of EMS □ Delay on routw □ other	***Primary Reason for Transport:*_____ *(indicate)*** **Was EMS used to transport to hospital?** □ Yes □ No □ Unknown
Where there any consults, transfers of care, or use of hospital/outpatient/emergency services during the postpartum period Yes_____ No_____	**2 consultation records provided. If additional are needed, please attach to record.**
Reason(s) for consultation/transfer of care? **Consult with Physician?** Yes_____ No_____ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Transfer of Care?** Yes_____ No_____ **Rationale for Transfer of Care:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Transfer of Care returned?** Yes_____ No_____	**Reason(s) for consultation/transfer of care?** **Consult with Physician?** Yes_____ No_____ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Transfer of Care?** Yes_____ No_____ **Rationale for Transfer of Care:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify_____ **Transfer of Care returned?** Yes_____ No_____
Visit Summary	
# of visits postpartum: Coordinating MW **# Visits postpartum – all other midwives** **# of visits in which a student was involved** **Total # of Registered Midwives providing postpartum care:**	**# Postpartum visits home:** **# Postpartum visits hospital:** **# Postpartum visits clinic:**

Was the client discharged from Midwifery care during the postpartum period? (Select Yes to discharge client from Midwifery Care and/or bill for the Course of Care) Yes_____ No_____

Note: Billing information listed on Antenatal General Encounter front page