THRIVE Newborn Home Visit Assessment

Mom's Information

Name (Last, First, Middle initial)	
Address	
Cell Phone	Primary Language Is an interpreter needed?
Date of Birth	Age
Race (check all the apply): ___ American Indian or Alaskan Native ___ Asian ___ Black/African American ___ Native Hawaiian or Other Pacific Islander ___ White/Caucasian ___ Other _____ Ethnicity: ____ Hispanic ____ Non-Hispanic	Employment ____ Full time ____ Part time ____ Unemployed Education Level ____ Less than High School ____ High School Grad ____ GED ____ Some College ____ College Degree
Previous births □ Yes □ No Previous loss of baby □ Yes □ No	
Current Enrollments □ WIC □ SPARK □ Community Health Worker □ Ohio Means Job □ Help Me Grow □ Early Head Start □ KOBA □ SNAP	

Father's Information

Name (Last, First, Middle Initial)
Does he live in the home? □ Yes □ No
Was dad present during visit? □ Yes □ No
Employment ____ Full time ____ Part time ____ Unemployed

Other Household Members

Adults and relationship to mom:

_____

_____

_____

_____

Children and ages:

_____

_____

Home and Social Environment

Pets in the Home? □ Dog □ Cat □ Iguana □ Other _____ Pet Safety discussed □ Yes □ No	
Does home have: □ Smoke Detectors - #_____ in home / Battery Education Provided □ Yes □ No □ Carbon Monoxide Detector - #_____ in home / Battery Education Provided □ Yes □ No □ Refrigerator □ Microwave – safety discussed □ Yes □ No	
Does anyone smoke in the home? □ Yes □ No	Smoke in the car with baby? □ Yes □ No
Child Safety Restraint: □ Infant seat □ Convertible Car Set	Is baby riding rear-facing in the back seat of vehicle? □ Yes □ No

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Caregiver Skills: Mom and/or primary caregiver _____

Bottle/Formula Prep/ storage □ Yes □ No	Pumped Breast Milk □ Yes □ No Storage and Handling Discussed □ Yes □ No	Diapers/Diapering □
Clothing □ Overheating discussed □	Supervised Tummy Time □	Handling/Positioning □
Bathing/Cord Care □	Oral Health □	
Where does baby sleep at home? _____ … at childcare/caregiver's/grandparents? _____ Baby sleeps on back? □ Yes □ No Safe sleep environment: _____ home _____childcare _____caregiver's home		

Maternal/Postpartum Assessment

Medications: _____ Prenatal Vitamins: During pregnancy □ Yes □ No Currently □ Yes □ No Iron Supplement: During pregnancy □ Yes □ No Currently □ Yes □ No		
Tdap Vaccine during pregnancy? □ Yes □ No		
Vital Signs: ____/_____ BP Prenatal Complications □ Yes □ No _____		
□ Vaginal Birth □ C-Section	Is the incision healing? □ Yes, no s+s of infection	Is the Perineum healing □ Yes, no s+s of infection (self-reported by mom)
Gestational Diabetes □ Yes □ No	Lochia: Rubra (heavy) □ Serosa □ Alba □	
If breastfeeding: BF every 2.5 – 3 hrs during the day and at least once at night? □ Yes □ No Working with Lactation Consultant □ Yes □ No Nipples cracked or sore? □ Yes □ No		
How often is mom eating?	Fluid Intake?	
Mom voiding w/o difficulty? □ Yes □ No	Mom's bowel pattern normal? □ Yes □ No	
Postpartum appointment made? □ Yes □ No When?_____		
Does mom have a plan for Birth Control? □ Yes □ No Safe spacing discussed □ Yes □ No		
Concerns discussed with OB/GYN □ Yes □ No		

Mom's Activity Level

___ Rests frequently, lying down with feet elevated
___ If not breastfeeding, wear supportive bra day and night. Use ice packs if needed for breast discomfort: avoid hot showers.

Psycho-Social Assessment

Observation of Nurse: ___ Mom establishes eye contact with baby ___ Mom talks and sings to baby ___ Mom holds baby close: touches, strokes, rocks baby ___ Infant sleeping majority of visit
How are others in the home adjusting?
How does partner feel about your baby? ____ Happy ____ Anxious _____ Not involved
Do you have resources to keep yourself and your baby healthy? If no, what needs exist? __ housing __financial __food __family __other
Do you have family/friend support? □ Yes □ No

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Edinburgh Postpartum Depression Scale completed: □ Yes □ No Score _____ Physician informed? □ Yes □ No □ N/A Mom Refused □ If previous births, was postpartum depression diagnosed □ Yes □ No □ N/A

Parenting Skills

Bonding □ Observed □ Discussed	Respond to cues/crying □ Observed □ Discussed	Shaken Baby Syndrome Education □ Yes □ No
Did Baby receive first dose of Hepatitis B vaccine in hospital? Y N		
Well Child Check –Up Scheduled? □ Yes □ No When is the appointment_____		
Appt made for first set of shots? □ Yes □ No When is the appointment_____		
Child care arranged? □ Yes □ No		

Baby's Information

Name (Last, First, Middle)	Due Date
Date of Birth	Age
Birth Length	Birth Weight
Race (check all the apply): ___ American Indian or Alaskan Native ___ Asian ___ Black/African American ___ Native Hawaiian or Other Pacific Islander ___ White/Caucasian ___ Other _____	Ethnicity ____ Hispanic ____ Non-Hispanic Gender ____ Male ____ Female

Newborn Assessment

Any prenatal complications: □ Yes □ No If yes, explain:	
Labor/Delivery complications? □ Yes □ No If yes, explain: Birthing Facility? _____	
Newborn Hearing screening done? □ Yes □ No Needs follow-up testing □ Yes □ No	Newborn Metabolic screening done? □ Yes □ No □ Unsure
Color: □ pink/ruddy when crying □ pink centrally when resting Jaundice: □ Yes □ No Bilirubin testing since discharge □ Yes □ No Last Done _____	
Current Weight:_____ lbs or grams Dry diaper and dressed □ Yes □ No Naked (no diaper) □ Yes □ No	
Sternal retractions, grunting, or nasal flaring? □ Yes □ No	

Health

Circumcision? □ Yes □ No □ N/A	Healing well (yellow exudate forming and nonbleeding)? □ Yes □ No	
Cord appearance: _____ Cord care and education given □ Yes □ No		
Cord odorous? □ Yes □ No	Cord drying process evident? □ Yes □ No	Signs/Symptoms of infection? □ Yes □ No
Abdomen soft and flat? □ Yes □ No Abdomen firm and round? □ Yes □ No		Fontanels: □ Normal □ Flat □ Depressed □ Bulging
Eyes: ___Clear ____ regards face Exudate Present □ LE □ RE □ N/A Matting of Eyes □ LE □ RE □ N/A Blocked tear ducts □ LE □ RE □ N/A		

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Feeding/Nutrition

Breastfeeding? □ Yes □ No Baby Latching? □ Yes □ No Feeding Frequency _____ Length of feedings? _____
Bottle feeding? □ Yes □ No □ Supplementing Feeding Frequency _____ Amount of Feeding _____ Formula Name:
Weight gain since birth? □ Yes □ No How much?
How many wet diapers per day? _____ (6-10 per day normally)
How many stools per day? _____ (Breastfed – 2-3 per day. Bottle, at least 1 every 48 hrs)

Activity

Has 4-5 wakeful periods per day? □ Yes □ No Alert to sounds and voices? □ Yes □ No	Makes eye contact with mom or caregiver? □ Yes □ No Does baby quiet when picked up? □ Yes □ No
Amount of crying:	

Referrals

- □ Family Planning
- □ OB/GYN
- □ Pediatrician
- □ Lactation Consultant
- □ BCMH
- □ Childcare
- □ WIC
- □ Help Me Grow
- □ Domestic Violence
- □ Medication Assistance
- □ Ohio Guidestone
- □ Community Health Worker (THRIVE)
- □ Housing
- □ Transportation
- □ Insurance/Medicaid
- □ Substance Use
- □ Tobacco Cessation
- □ Other:

Concerns:

_____

_____

_____

Education Materials given:

- □ Family Planning/LARC
- □ Childhood Immunizations
- □ Brain Development
- □ Keeping child safe from lead
- □ Safe Sleep
- □ Tdap for Caregivers
- □ Tummy Time
- □ Car Seat Safety
- □ Breastfeeding
- □ Postpartum Depression
- □ Infant Care
- □ Pet Safety

Notes:

_____

_____

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