Birth Summary Report / Postnatal Outcomes

Infant's Name: _____ **DOB:** _____
(First, Last)

Mother's Name: _____ **DOB:** _____
(First, Last)

Mother's Medicaid #:_____ **Mother's Social Security #**:_____

Infant's Medicaid #:_____ **Infant's Social Security #**:_____

Infant's Race/Ethnicity: ____ Black ____White ____ Hispanic ____Other (specify) _____

Address: _____ **City** _____ **State** _____ **Zip Code** _____

DELIVERY OUTCOME
Estimated Date of Delivery: ___ month ___day ___year **Actual Delivery Date:** ___ month ___day ___year

Delivery Facility: _____ ***Delivery Outcome:** ___Live Birth ___Stillborn ___Miscarriage

Was the Delivery Premature (less than 37 weeks): ___Yes ___ No **# of Weeks at Delivery:** _____

Infant's Sex: ___Male ___ Female ***Birth weight:** ____ pounds _____ ounces **Type of Delivery:** ___Vaginal ___Cesarean

Complications of the Pregnancy? ___Yes ___ No
If Yes, check all that apply: ___ Preeclampsia ___ Eclampsia ___ Preterm Labor ___ Breech
___ Infection ___ Diabetes ___ Other (specify) _____

***Complications with Baby?** ___ Yes ___ No
If Yes, check all that apply: ___ Congenital Anomalies ___ Infant Admitted in NICU ___ Neonatal Death (birth - 28 days)
___ Post-neonatal Death (28 - 364 days) ___Other (specify) _____

BABY CARE
Health Insurance? ___Medicaid ___ KidCare ___Private Insurance ___ No insurance

***Child with a Permanent Medical Home:** ___Yes ___ No **Name of Pediatrician:** _____

***Immunization received at:** (check all that apply) ___ Birth ___ 2 months ___ 4 months ___ 6 months ___12 months

Well Baby Check-up occurred at: (check all that apply) ___ 2 months ___ 4 months ___ 6 months ___9 months and after

***2nd Hand Smoke Exposure During Care Coordination:** ___Unknown ___None ___Continued ___Reduced __Discontinued

***Bed Sharing:** ___Unknown ___Always ___Often ___Sometimes ___Rarely ___Never

***Most Common Sleep Position:** ___Unknown ___The Back ___The Side ___The Stomach

***Was breastfeeding initiated at birth?** ___Yes ___ No **Current Nutrition:** ___ Breastfeeding ___ Formula ___Both

***Breastfeeding Duration:** ___1 day-6 week's __7 weeks-3 months ___4-6 months ___7-12 months ___more than 12 months

***Pacifier Use:** ___Yes ___No

MOTHER'S CARE
***Postpartum Visit:** _____ **Family Planning Method:** _____ **Vitamin:** _____
Date

Health Insurance? ___Medicaid ___ Private Insurance ___ No insurance

Social Support: (check all that apply) ___Father of Baby ___Family ___Friends ___ No Support

Care Coordinator Name: _____ Care Coordinator Signature: _____

Date Form Completed: _____ Care Service Site: _____