

CPSP Postpartum Assessment and Individualized Care Plan

Refer to previous assessments, note any changes and update the patient's individualized care plan

Patient Identifier _____

Baby

1. Baby's DOB: _____ Birth site: _____

2. Name: _____ Male Female

3. Weight at birth: _____ Lbs./oz. or _____ grams

4. Length at birth: _____ Inches or _____ cm

5. Weeks gestation _____ 6. Type of delivery: _____

7. If multiple births, give information on other babies:

Psychosocial

Psychosocial Risks/Concerns	Psychosocial Individualized Care Plan Developed with Client	Comment
1. Did you have any issues with delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
2. Does the baby have any medical issues? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred for genetic screening before next pregnancy <input type="checkbox"/> Referred to/for:	
3. What are you enjoying most about your new baby? Describe: What is most challenging? Describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Client discussed how to soothe the baby <input type="checkbox"/> Referred to/for:	
4. Are family members adjusting to the baby? <input type="checkbox"/> Yes <input type="checkbox"/> No, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
5. Are you getting the support you need from your family/partner? <input type="checkbox"/> Yes <input type="checkbox"/> No, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Client identified sources of support: <input type="checkbox"/> Referred to/for:	
6. Have you had any emotional concerns that need follow up? <input type="checkbox"/> No <input type="checkbox"/> Yes Over the past two weeks, have you felt down, depressed or hopeless? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: Have you had little interest or pleasure in doing things? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: For the past month, more days than not, have you felt anxious, nervous, worried, irritable, or overwhelmed? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: If you added up all of the time you have slept, how many hours would you say you have been able to sleep per day in the past two days? <input type="checkbox"/> less than 4 hours <input type="checkbox"/> 4-8 hours <input type="checkbox"/> More than 8 hours/day	<input type="checkbox"/> Client reviewed STT PSY handout: How Bad are your Blues? <input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to OB provider <input type="checkbox"/> Referred to Postpartum Support International 1-800-944-4PPD or postpartum.net, other: <input type="checkbox"/> Scheduled a return visit <input type="checkbox"/> Refer to provider if sleeping less than 4 hours/day for past two days.	
7. Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe If not breastfeeding or pregnant: >3 drinks/day, 7/week in past three months is risk.	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Will not use any alcohol if planning to become pregnant <input type="checkbox"/> If breastfeeding, wait 3 hours after alcohol before breastfeeding or expressing milk for baby's use. <input type="checkbox"/> Referred to/for	
8. Do you use drugs other than prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Client understands to delay another pregnancy until drug free <input type="checkbox"/> Referred to/for:	

Psychosocial Risks/Concerns	Psychosocial Individualized Care Plan Developed with Client	Comment
9. Do you smoke or do people smoke around you or the baby(including e-cigarettes)? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	<input type="checkbox"/> Client goal/plan: Client understands <input type="checkbox"/> not to smoke around baby <input type="checkbox"/> Quit for her health. <input type="checkbox"/> Referred to/for: 1-800-no-BUTTS, other _____	
10. Within the past year, has your partner hit, slapped, kicked, choked, and forced you to have sex, or otherwise physically or emotionally hurt you? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: Client understands: <input type="checkbox"/> STT PSY: Safety when Preparing to leave <input type="checkbox"/> Cycle of Violence <input type="checkbox"/> National DV hotline 1-800-799-SAFE <input type="checkbox"/> Referred to OB provider <input type="checkbox"/> Mandated reporting completed, date: _____ for: _____ <input type="checkbox"/> Local resources:	
11. What are your plans for the future: <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
12. Do you need help finding childcare? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
13. Do you need essential baby supplies (diapers, clothing, and other supplies)? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
14. Do you have any other social, emotional or financial concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
15. Reviewed the assessment with Client and identified the following strengths:		

Completed by: _____ Psychosocial minutes spent: _

Signature

Title

Date

Signature of MD if completed by CPHW _____

Health Education

Health Education Risks/Concerns	Health Education Individualized Care Plan Developed with Client	Comment
1. Do you have any questions about body changes, postpartum discomforts or self-care after pregnancy? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe: Are you receiving Text4Baby? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No,	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to OB provider <input type="checkbox"/> Client will sign up for Text4Baby	
2. How many children are you planning to have? _____ How far apart? _____ Are you using birth control? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, type _____ If No, why not? _____ What method(s) of birth control are you interested in? Do you have any concerns about your ability to use birth control? <input type="checkbox"/> Forgetting to use birth control <input type="checkbox"/> Birth control could fail <input type="checkbox"/> Partner does not support her use of birth control <input type="checkbox"/> Other:	Client goal/plan: <input type="checkbox"/> Discussed birth control methods, including LARCs <input type="checkbox"/> Method selected: _____ <input type="checkbox"/> Has family planning appointment <input type="checkbox"/> Referred to family planning provider <input type="checkbox"/> Understands emergency birth control Client will consult with OB provider: <input type="checkbox"/> If planning to get pregnant again less than 18 months after the birth of this child. <input type="checkbox"/> If patient's partner does not support her use of birth control, knows that there are methods partner does not have to know about. <input type="checkbox"/> Client knows to wait at least 18 months, take folic acid, control chronic conditions, avoid chemical exposure before conceiving again, obtain preconception counseling before next pregnancy	
3. Are you exposed to chemicals or toxins at home or elsewhere? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe	<input type="checkbox"/> Client understands risks, will avoid exposure	
4. Do you have health insurance for your own health care in the future? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to clinic eligibility worker	
5. Do you have a doctor for regular medical checkups? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, describe: Primary care provider name: _____	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to/for:	
6. Has a doctor told you that you have any health issues that need follow up? (diabetes, hypertension, obesity, depression, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to primary care provider Name _____ _____	
7. Did you see a dentist during pregnancy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, describe:	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to dental provider:	
8. Do you have any sore/bleeding gums, sensitive/loose teeth, bad taste or smell in mouth? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe:	<input type="checkbox"/> Client goal/plan: Follow STT HE <input type="checkbox"/> Prevent Gum Problems <input type="checkbox"/> See a Dentist <input type="checkbox"/> Keep Teeth Healthy <input type="checkbox"/> Referred to dental provider:	
9. Do you have a doctor and appointment for the baby? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Name of provider: _____ Appt. date: _____	<input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to CHDP/pediatric provider:	

Health Education Risks/Concerns	Health Education Individualized Care Plan Developed with Client	Comment
10. Do you have any questions about <input type="checkbox"/> newborn care, <input type="checkbox"/> car seat <input type="checkbox"/> immunizations, <input type="checkbox"/> health <input type="checkbox"/> Where does baby sleep? _____ <input type="checkbox"/> What position does baby sleep in? _____ Safety: <input type="checkbox"/> Chemicals/cleaning supplies <input type="checkbox"/> Electric outlets <input type="checkbox"/> Hot water temp <input type="checkbox"/> Exposed water (toilets, pools) <input type="checkbox"/> Other describe: _____	<input type="checkbox"/> Client goal/plan: Discussed <input type="checkbox"/> Bathing <input type="checkbox"/> Diapering <input type="checkbox"/> Safe sleep <input type="checkbox"/> Other: Follow STT HE <input type="checkbox"/> Keep Your New Baby Safe and Healthy <input type="checkbox"/> Baby Needs to be Immunized <input type="checkbox"/> When Newborn is Ill <input type="checkbox"/> Safe Sleep <input type="checkbox"/> Has infant car seat <input type="checkbox"/> Referred to/for <input type="checkbox"/> Client goal/plan:	
11. Do you have a dentist for the baby? <input type="checkbox"/> Yes, <input type="checkbox"/> No Name of provider: _____	<input type="checkbox"/> Client goal/plan: Take baby to see dentist at first year/first tooth <input type="checkbox"/> STT: Protect Your Baby From Tooth Decay <input type="checkbox"/> Referred to dental provider	
12. Other question or need? <input type="checkbox"/> Yes, <input type="checkbox"/> No	<input type="checkbox"/> Client goal/plan:	
13. Reviewed assessment with client and client identified the following strengths:		

Completed by: _____ Health Ed. minutes spent: _____
 Signature Title Date

Signature of MD if completed by CPHW _____

Nutrition

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Comment																																	
Anthropometric: Height, Weight, & Body Mass Index (BMI)																																			
1. Total weight gain: _____ lbs. Height: _____ Weight at this visit: _____ lbs. BMI: _____ Desired weight: _____ Client's Weight Goal: _____ Client's Target BMI: _____ <input type="checkbox"/> Normal weight <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Obese	Client acknowledges: <input type="checkbox"/> Healthy weight range (18-24.9 BMI) <input type="checkbox"/> Client's weight goal : _____ <input type="checkbox"/> Aim for lower caloric intake STT My Plate for Moms/My Nutrition Plan for Moms or WIC Be a Healthy Mom handout <input type="checkbox"/> Aim to be physically active each day <input type="checkbox"/> Referral to RD (date): _____ <input type="checkbox"/> Referral to (profession, reason and date): _____																																		
Biochemical: Lab Values																																			
2. HGB _____ HCT _____ Glucose _____ Date: _____ Any abnormal lab values? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____	<input type="checkbox"/> Discussed issues with provider. Client reviewed STT N handout(s): <input type="checkbox"/> Get The Iron You Need <input type="checkbox"/> If You Need Iron Pills <input type="checkbox"/> Iron Tips <input type="checkbox"/> Iron Tips: Take Two <input type="checkbox"/> My Action Plan for Iron <input type="checkbox"/> Referred to RD (date): _____ <input type="checkbox"/> Referred to (profession, reason and date): _____ _____ <input type="checkbox"/> Client will: _____																																		
Clinical																																			
3. Are there any nutrition-related health issues? <input type="checkbox"/> Under 19 years of age <input type="checkbox"/> Currently breastfeeding another child <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Ever had an eating disorder, such as anorexia, bulimia, disordered eating <input type="checkbox"/> Other current or previous nutrition related health issues: _____	<input type="checkbox"/> Discuss issues with provider <input type="checkbox"/> Client goal/plan: <input type="checkbox"/> Referred to RD (date): _____ <input type="checkbox"/> Referral to (profession, reason and date): _____ _____																																		
Dietary																																			
4. Which of the following are you taking? <table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Which one?</th> <th style="text-align: center;">How much /often?</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Iron</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Folic Acid</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Prenatal vitamins/minerals</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Other vitamins or mineral</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Home remedies or herbs/teas</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Liquid or powdered supplements</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Laxatives</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Prescription medicines</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Antacids</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> Over-the-counter medicines</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Which one?	How much /often?	<input type="checkbox"/> Iron	_____	_____	<input type="checkbox"/> Folic Acid	_____	_____	<input type="checkbox"/> Prenatal vitamins/minerals	_____	_____	<input type="checkbox"/> Other vitamins or mineral	_____	_____	<input type="checkbox"/> Home remedies or herbs/teas	_____	_____	<input type="checkbox"/> Liquid or powdered supplements	_____	_____	<input type="checkbox"/> Laxatives	_____	_____	<input type="checkbox"/> Prescription medicines	_____	_____	<input type="checkbox"/> Antacids	_____	_____	<input type="checkbox"/> Over-the-counter medicines	_____	_____	<input type="checkbox"/> Discussed issues with provider. Client reviewed STT N handout(s): <input type="checkbox"/> Take Prenatal Vitamins and Minerals <input type="checkbox"/> Get the Folic Acid You Need <input type="checkbox"/> Folic Acid: Every Woman, Every Day _____ <input type="checkbox"/> Get The Iron You Need <input type="checkbox"/> If You Need Iron Pills <input type="checkbox"/> Iron Tips _____ <input type="checkbox"/> Iron Tips: Take Two _____ <input type="checkbox"/> My Action Plan for Iron <input type="checkbox"/> Vitamin B12 is Important <input type="checkbox"/> Foods Rich in Calcium <input type="checkbox"/> You May Need Extra Calcium <input type="checkbox"/> Constipation: What You Can Do <input type="checkbox"/> Referred to RD (date): _____ <input type="checkbox"/> Referral to (profession, reason and date): _____ <input type="checkbox"/> Will continue prenatal vitamins until gone <input type="checkbox"/> Client acknowledges that after prenatal vitamins are gone, take vitamins with 400 micrograms folic acid <input type="checkbox"/> Client will: _____	
	Which one?	How much /often?																																	
<input type="checkbox"/> Iron	_____	_____																																	
<input type="checkbox"/> Folic Acid	_____	_____																																	
<input type="checkbox"/> Prenatal vitamins/minerals	_____	_____																																	
<input type="checkbox"/> Other vitamins or mineral	_____	_____																																	
<input type="checkbox"/> Home remedies or herbs/teas	_____	_____																																	
<input type="checkbox"/> Liquid or powdered supplements	_____	_____																																	
<input type="checkbox"/> Laxatives	_____	_____																																	
<input type="checkbox"/> Prescription medicines	_____	_____																																	
<input type="checkbox"/> Antacids	_____	_____																																	
<input type="checkbox"/> Over-the-counter medicines	_____	_____																																	

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Comment
<p>5. Are you on a special diet, including reducing or eating extra calories? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe: _____</p> <p>Do you limit or avoid any food or food groups (such as meat or dairy)? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe: _____</p> <p>Why do you avoid these foods?</p> <p><input type="checkbox"/> Do not like <input type="checkbox"/> Personal Choice</p> <p><input type="checkbox"/> Intolerance <input type="checkbox"/> Physician advice</p> <p><input type="checkbox"/> Allergy <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Discussed issues with provider.</p> <p>Client reviewed STT N handout(s):</p> <p><input checked="" type="checkbox"/> When You Are a Vegetarian: What Do You Need To Know</p> <p><input type="checkbox"/> Choose Healthy Foods</p> <p><input type="checkbox"/> Foods Rich in Calcium</p> <p><input type="checkbox"/> Do You Have Trouble with Milk Foods?</p> <p><input type="checkbox"/> You May Need Extra Calcium</p> <p><input type="checkbox"/> Vitamin B12 is Important</p> <p><input type="checkbox"/> Constipation: What You Can Do</p> <p><input type="checkbox"/> Get the Iron You Need</p> <p><input type="checkbox"/> Get the Folic Acid You Need</p> <p><input type="checkbox"/> Referred to: _____</p> <p><input type="checkbox"/> Referred to RD (date): _____</p> <p><input type="checkbox"/> Referral to (profession, reason and date): _____</p> <p><input type="checkbox"/> Client will: _____</p>	
<p>6. How is infant feeding going overall?</p> <p>_____</p> <p>How many times in 24 hours, day and night do you feed your baby:</p> <p>____ Breastmilk ____ Formula ____ Water ____ Juice</p> <p>____ Baby Foods ____ Table foods ____ Other,</p> <p>Describe: _____</p> <p>Does your baby ever go more than three hours between feedings? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> Number wet diapers/day _____</p> <p><input type="checkbox"/> Number dirty diapers/day _____</p> <p>Using pacifier? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Does baby take a supplement with vitamin D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (see guidance in care plan)</p> <p>Are you planning to return to work or school?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, explain: _____</p> <p>If breastfeeding, are you having any of these concerns?</p> <p><input type="checkbox"/> Cracked, sore nipples</p> <p><input type="checkbox"/> Not enough milk</p> <p><input type="checkbox"/> Baby doesn't take breast easily</p> <p>What breastfeeding questions can we answer today?</p>	<p>Client goal/plan: follow STT N handouts:</p> <p><input checked="" type="checkbox"/> A Guide to Breastfeeding</p> <p><input type="checkbox"/> <i>Tips for Addressing Breastfeeding Concerns</i></p> <p><input type="checkbox"/> <i>What to Expect while Breastfeeding: Birth to Six Weeks</i></p> <p><input type="checkbox"/> Breastfeeding Checklist for My Baby and Me</p> <p><input type="checkbox"/> Breastfeeding and Returning to Work or School</p> <p><input type="checkbox"/> Nutrition and Breastfeeding: Common Questions and Answers</p> <p><input type="checkbox"/> My Breastfeeding Resources</p> <p><input type="checkbox"/> Plans to exclusively breastfeed for 6 months and after 6 months, plans to continue breastfeeding with the addition of solid foods</p> <p><input type="checkbox"/> Use local breastfeeding resources: _____</p> <p><input type="checkbox"/> Referred to provider for Vitamin D supplement if exclusively breastfeeding or consuming less than 1 quart (32 oz.) of infant formula per day.</p> <p><input type="checkbox"/> Referred to (profession, reason and date): _____</p> <p><input type="checkbox"/> Client will: _____</p>	
<p>7. Have you fasted while breastfeeding or do you plan to fast while breastfeeding? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, describe: _____</p> <p>_____</p> <p><input type="checkbox"/> How often: _____</p> <p><input type="checkbox"/> How long: _____</p>	<p><input type="checkbox"/> Client goal/plan: follow</p> <p><input checked="" type="checkbox"/> Making Plenty of Milk and <input type="checkbox"/> How to Know your Baby is Getting Plenty of Milk in <i>What to Expect in the First Week of Breastfeeding</i></p> <p><input type="checkbox"/> You Can Pump and Store</p> <p><input type="checkbox"/> Use local breastfeeding resources:</p> <p><input type="checkbox"/> Referred to RD (date): _____</p> <p><input type="checkbox"/> Referral to (profession, reason and date): _____</p> <p>_____</p> <p><input type="checkbox"/> Client will: _____</p>	
<p>8. Do you have the following?</p> <p><input type="checkbox"/> Oven <input type="checkbox"/> Electricity <input type="checkbox"/> Microwave</p> <p><input type="checkbox"/> Stove <input type="checkbox"/> Refrigerator</p> <p><input type="checkbox"/> Clean running water</p> <p><input checked="" type="checkbox"/> Missing any of the above</p>	<p>Client reviewed STT N handout(s):</p> <p><input checked="" type="checkbox"/> Tips for Cooking and Storing Food</p> <p><input checked="" type="checkbox"/> When You Cannot Refrigerate, Choose These Foods</p> <p><input checked="" type="checkbox"/> Tips for Keeping Food Safe</p> <p><input type="checkbox"/> Referred to RD (date): _____</p> <p><input type="checkbox"/> Referred to (profession, reason and date): _____</p> <p>_____</p> <p><input type="checkbox"/> Client will: _____</p>	

Nutrition Risks/Dietary Issues	Nutrition Individualized Care Plan Developed with Client	Comment
<p>9. In the past month, were you worried whether your food would run out before you or your family had money to buy more? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, Explain:</p> <p>In the past month, were there times when the food that you or your family bought just did not last and you did not have money to get more? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, Explain:</p> <p>Do you use any of the following food resources?</p> <ul style="list-style-type: none"> • WIC: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes WIC Site: _____ • CalFresh (food stamps)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Have you used any other food resources, such as food banks, pantries or soup kitchen? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 	<p>Client reviewed STT N handout(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> You Can Eat Healthy and Save Money: Tips For Food Shopping <input type="checkbox"/> You Can Stretch Your Dollars: Choose These Easy Meals and Snacks <input type="checkbox"/> You Can Buy Low-Cost Healthy Foods <input type="checkbox"/> Referred client to WIC <input type="checkbox"/> Referred client to CalFresh (Food Stamps) <input type="checkbox"/> Referred client to local emergency food resources <input type="checkbox"/> Referred to RD (date): _____ <input type="checkbox"/> Referred to (profession, reason and date): _____ <p><input type="checkbox"/> Client will:</p>	
<p>10. What kinds of physical activity do you do? _____ How often? _____ How long? _____</p> <p>On an average day, are you physically active at least 30 minutes each day? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>On an average day, do you spend over 2 hours watching TV or other screen? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, explain:</p> <p>Has a doctor told you to limit your activity? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes If yes, Explain:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Client identified ways to be more active each day <input type="checkbox"/> Referred to (profession, reason and date): _____ <p><input type="checkbox"/> Client will</p>	
<p>11. Complete Nutrition Assessment using one of these forms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 24-hour Perinatal Dietary Recall or <input type="checkbox"/> Perinatal Food Group Recall or <input type="checkbox"/> Approved Food Frequency Form 	<ul style="list-style-type: none"> <input type="checkbox"/> Client identifies strengths and weaknesses demonstrated by nutrition assessment: <hr/> <p>Client agrees to follow STT N handout(s) (indicate date):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Choose Healthy Foods To Eat <input type="checkbox"/> Vegetarian Eating <input type="checkbox"/> Get The Iron You Need <input type="checkbox"/> If You Need Iron Pills <input type="checkbox"/> Iron Tips <input type="checkbox"/> Iron Tips: Take Two <input type="checkbox"/> My Action Plan for Iron <input type="checkbox"/> Get The Folic Acid You Need <input type="checkbox"/> Get The Vitamin B₁₂ You Need <input type="checkbox"/> Food Rich in Calcium <input type="checkbox"/> If you Had Diabetes While You Were Pregnant <input type="checkbox"/> Now That Your Baby Is Here <input type="checkbox"/> My Nutrition Plan for Moms 	
<p>12. Other risk or dietary issue?</p>	<p><input type="checkbox"/> Client goal/plan:</p>	
<p>13. Reviewed assessment with client and client identified the following strengths:</p>		

Completed by: _____ Nutrition minutes spent: _____
Signature Title Date

Signature of MD if completed by CPHW _____