Patient Label Here

Postpartum Mother Encounter
Midwifery

Was this patient admitted to this organization for Postpartum Care only (the birth did not occur at the admitting hospital)? □ Yes □ No

If yes, complete all sections. If no, proceed to Section: Postpartum Complication

Admission Date: dd/mmm/yyyy **Admission Time:** hours

Admission By Healthcare Provider: □Obstetrician □Family Physician □Midwife □Nurse Practitioner (CNS/APN) □Other

Maternal Transfer From: □ Hospital and Name of Hospital: _____ □ Birth Centre and Name: _____
□Home Birth/MW Care and Name: _____ □ Home □ Nursing Station □ Other Unit Same Hospital □ Other

Reason for Maternal Transfer: □ Lack of nursing coverage □ Lack of physician coverage □ Maternal medical/obstetrical 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

Date of Delivery/Newborn DOB: dd/mmm/yyyy **Time of Birth:** hours

Type of Birth: □ Spontaneous vaginal birth □Assisted Vaginal Birth □Induced or spontaneous labour Caesarean Section □No Labour Caesarean Section

Birth Location: □Hospital and Name of Hospital: _____ □ Birth Centre and Name of Birth Centre: _____
□ Home □Nursing Station □ Other Ontario Location □ Outside of Ontario

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

Was Postpartum Breastfeeding Support Provided? □ Yes □ No □ Unknown

If Yes is selected, then complete the following:

Provided information/support regarding: (*select all that apply*)

- □ Hand expression
- □ Pumping
- □ Skin-to-skin
- □ Signs of effective latch
- □ Continuation of breastfeeding after discharge

□ Sustained breastfeeding if separated from baby
□ Community breastfeeding resources
□ Provided assistance with breastfeeding within six hours of delivery after initial feeding
□ Consult with a lactation consultant
□ Referred mother to breastfeeding support services for follow-up
If No is selected, then complete the following:
Reason why postpartum breastfeeding education and support was not provided: *(single select)*
□ Not applicable
□ Early discharge home within 2 hours
□ Mother declined
□ Other
□ Unknown

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

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
Infant Discharged with Mother: □yes □no

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 route □ other	***Primary Reason for Transport:***_____ ***(indicate)*** **Was EMS used to transport to hospital?** □ Yes □ No □ Unknown
Postpartum Consultation/Transfer of Care 1: **Where there any postpartum consultations or transfers of care from approximately 1 hour post-birth to discharge from midwifery care?** Yes_____ No_____	**Postpartum Consultation/Transfer of Care 2: (If additional C/ToC's are needed, attach to record).** **Where there any postpartum consultations or, transfers of care from approximately 1 hour post-birth to discharge from midwifery care?** Yes_____ No_____
Postpartum Consultation/Transfer of Care Reason(s): **Postpartum Consultation(s) with Physician?** Yes_____ No_____ **Transfer of Care?** Yes_____ No_____ **Was consult (or transfer of care) due to physician/hospital protocol?** Yes_____ No_____ **Was transfer of care returned anytime from approximately 1 hour post-birth to discharge from midwifery care?** Yes_____ No_____	**Postpartum Consultation/Transfer of Care Reason(s):** **Postpartum Consultation(s) with Physician?** Yes_____ No_____ **Transfer of Care?** Yes_____ No_____ **Was consult (or transfer of care) due to physician/hospital protocol?** Yes_____ No_____ **Was transfer of care returned anytime from approximately 1 hour post-birth to discharge from midwifery care?** Yes_____ No_____
Visit Summary & Location	
# Visits postpartum by Coordinating MW: _____ **# Visits postpartum by all other midwives:** _____ **# Visits postpartum, in which a student was involved:** _____ **Total # of Registered Midwives providing postpartum care:** _____	**# Postpartum visits home:** _____ **# Postpartum visits hospital:**_____ **# Postpartum visits clinic:**_____ **# Postpartum visits virtual:** _____ **#Postpartum visits other location (eg. shelter, prison):** _____

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_____