

DOULAS CARE -- BIRTH CLIENT INFORMATION FORM

Instructions for filling out this form:

We are very grateful that you have accepted a client! Please remember that your commitment includes the following:

- Call the client to set up the first prenatal visit
- Meet 2 more times before the birth, if possible
- Be on-call 2 weeks before client's due date, and 2 weeks after her due date
- Support client during labor and immediately postpartum (at least 2 hrs)
- Notify the Center after client gives birth
- Arrange 3 postpartum visits (within first 3 days, a week later, up to 6 weeks postpartum)
- Turn in this client information form after the last client contact

If the woman transfers out of your care for any reason, or simply does not contact you when she is in labor, we still need this form.

Let us know if we can be of any help. We are here to answer any questions that you may have.

Please fill out these pages to the best of your ability. Answer each item by placing a check in the box or writing the answer in the space provided. Use one form per client. This information, including private health information, should be treated confidentially and not discussed or shared outside the context of your doula role.

When you have completed this form, please drop it off in person or mail it to...

**Doula Care
722 Brooks St.
Ann Arbor, Michigan 48103**

(734) 332-8070

Thank you for your efforts to collect data on doula support! It is very important to the successful continuation of this volunteer program.

DOULAS CARE -- BIRTH CLIENT INFORMATION FORM

Doula's Name: _____
Referral Date: _____ **Due Date:** _____
Client's Name: _____
Address: _____
Home Phone: _____ **Other Phone:** _____
E-mail: _____

PRENATAL INFORMATION:

Age of Mother: _____

Attended Childbirth Education Classes? no yes

If yes, what type: _____

Pregnancy: Normal

Gestational Diabetes

Pregnancy Induced Hypertension (PIH)

High Risk because _____

Other: _____

Pregnancy # _____

Birth # _____

Previous births:

Weeks gestation _____ Baby's weight _____

Weeks gestation _____ Baby's weight _____

Weeks gestation _____ Baby's weight _____

Planned... Cesarean

VBAC

Support: Name and Relationship of those planning on attending the birth...

Birth Plan? no yes

Noteworthy birth plans and/or expectations:

Prenatal Visits:

| Prenatal Visits | Date | Length (hours) | Site / Place | Key Issues |
|-----------------|------|----------------|--------------|------------|
| # 1 | | | | |
| # 2 | | | | |
| # 3 | | | | |
| # 4 | | | | |
| # 5 | | | | |

Information Given at the Prenatal Visits:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Baby Care <input type="checkbox"/> Birth Plan <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Breathing / Relaxation Techniques <input type="checkbox"/> Cesarean Surgery <input type="checkbox"/> Circumcision / Immunizations <input type="checkbox"/> Comfort Measures (non-drug methods of pain relief) <input type="checkbox"/> Communication with Care Provider(s) <input type="checkbox"/> Community Resources <input type="checkbox"/> Emotional Recovery <input type="checkbox"/> Epidural / Pain Medication Protocols <input type="checkbox"/> Episiotomy | <ul style="list-style-type: none"> <input type="checkbox"/> Mother/Infant Bonding <input type="checkbox"/> Nutrition and Exercise <input type="checkbox"/> Partner Support <input type="checkbox"/> Patient Rights and Hospital Protocols <input type="checkbox"/> Physical Recovery <input type="checkbox"/> Positions for Labor <input type="checkbox"/> Preparing for New Family <input type="checkbox"/> Role of the Doula <input type="checkbox"/> Other (please specify): _____ _____ <input type="checkbox"/> Other (please specify): _____ _____ |
|---|--|

Other Services Provided at the Prenatal Visits:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Attended birth classes <input type="checkbox"/> Attended prenatal appointments <input type="checkbox"/> Household needs <input type="checkbox"/> Other Children's needs | <ul style="list-style-type: none"> <input type="checkbox"/> Translation (language) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (please specify): _____ _____ |
|---|---|

Referrals Made:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> WIC <input type="checkbox"/> Medical Office/Clinic <input type="checkbox"/> Social Services <input type="checkbox"/> Health Department | <ul style="list-style-type: none"> <input type="checkbox"/> Social Work Services <input type="checkbox"/> Domestic Violence Shelter <input type="checkbox"/> Other (please specify): _____ _____ |
|--|--|

LABOR & BIRTH SUPPORT:

Date & Time of Birth: _____

Place of birth: _____

Birth Attendant: OB/GYN Family Practice Doctor
 Certified Nurse Midwife Direct-Entry Midwife
 Other: _____

Timing

Time labor contractions began: _____

Time ACTIVE labor began
(contractions 5 minutes apart): _____

Time you were first called: _____

Time & location where you met client: _____

Time you completed services: _____

Total time doula spent with laboring mom: < 1 hour 6-9 hrs 15-18 hrs > 24 hrs
 1-3 hrs 9-12 hrs 18-21 hrs
 3-6 hrs 12-15 hrs 21-24 hrs

Total time spent with mom immediately after birth: <1 hour 2-3 hours >4 hours
 1-2 hours 3-4 hours

If you spent more than 4 hours with mom after birth, please explain why:

Labor and Delivery Outcomes

Labor support measures that the woman reports she used at home (check all that apply):

- Breathing
- Massage
- Standing Squat
- Aromatherapy
- Walking
- Hydrotherapy
- Side Lying
- Food and Drink
- Hands and Knees
- Visualization / Relaxation
- Others: _____

Number of trips to the hospital: _____

If there was more than one trip, what was the reason for not staying at the hospital?

Motive for going to hospital (check all that apply): Water broke Pain Fatigue
 Active labor Other: _____

Dilatation when admitted to hospital: < 3 cm 5 cm 7 cm 9 cm
 4 cm 6 cm 8 cm 10 cm

Spontaneous Rupture of Membranes? yes no *If no, skip the next 2 questions*

Time: _____

Place: home hospital car
 other: _____

Length of Active Labor (0 to 10 cms): _____hrs _____mins
as perceived by mother

Length of Second Stage (pushing): _____hrs _____mins

Length of Third Stage: _____hrs _____mins

Total time from Admission to delivery: _____hrs _____mins

Comfort measures or labor support techniques you used with the mother (check all that apply):

- Breathing
 - Massage
 - Standing Squat
 - Aromatherapy
 - Walking
 - Hydrotherapy
 - Side Lying
 - Food and Drink
 - Hands and Knees
 - Visualization / Relaxation
 - Other: _____
 - Other: _____
 - Other: _____
 - Other: _____
-

Other labor support people present (check all that apply):

- Husband
 - Partner
 - Father
 - Mother
 - Friend
 - Sibling
 - Other (*please specify*) _____
 - Single, unaccompanied
-

Medications/Drugs used in Labor:

(use space below to provide additional explanation / information)

- Analgesic Medication (Narcotics such as Demoral, Buvain, Morphine, Stadol, etc)
 - Epidural Anesthesia
 - before 5 cm
 - after 5 cm
 - Other Medication: _____
 - Other Anesthesia: _____
-

Medical Interventions / Procedures during Labor:

(use space below to provide additional explanation / information)

- Electronic Fetal Monitoring...
 - Continuous
 - Intermittent
 - Both
- Internal Fetal Scalp Electrode
- Doppler (auscultation)
- Intrauterine Pressure Catheter
- Heplock
- IV
- Amniotomy (AROM) artificial rupture of membranes
- Amnio-infusion
- Prostaglandin Gel
- Pitocin Induction
- Pitocin Augmentation
- Other (during labor): _____

Method of Birth:

(use space below to provide additional explanation / information)

- Spontaneous Vaginal delivery
- Planned Cesarean delivery (Please note why)
- Unexpected Cesarean delivery (Please note why)
- Vaginal Birth after Cesarean (VBAC)
- Planned VBAC, but ended with Repeat Cesarean

- Forceps
- Vacuum extraction
- Episiotomy (degree _____)
- Tears / Lacerations (degree _____)

- Other Intervention: _____

- Other outcomes you want to note...

Were there any **medical complications** during labor and delivery? (check all that apply)

- Abnormal labor progress
- Infection
- Placenta previa
- Pre-eclampsia
- Preterm labor
- Multiple gestations (twins or more)
- Problems with amniotic fluid (too much or too little)
- Other: _____

Were you **prevented** from performing any comfort measures or desired birth plans due to ...

- hospital policy
- medical complications
- the woman's refusal.

If so, what is it that you could NOT do or provide?

- Comfortable labor environment (birth stool, lighting, music, etc.)
- Comfort measures (bathtub, shower, walking, positioning, etc)
- Communication with care providers
- Food preferences
- Other: _____

weeks gestation at delivery: _____ Wks

Mother's total weight gain during pregnancy: _____ Lbs

Baby's Sex: Male Female

Birth Weight: _____

Baby's Outcome:

Normal

Premature

Birth defect

Stillbirth

APGAR Scores: 1 minute _____

5 minutes _____

10 minutes _____

Complications with baby?

Abnormal heart tones

Breech

Low birth weight

Low blood sugar

Meconium Aspiration

Possible Infection

Other:

Transferred to NICU? yes no If yes, what time & why?

Baby with Mother less than 30 min in first hour yes no

Skin-to-Skin contact between mother and baby? yes no

Breastfeeding: yes no

Time of first feeding: < 1 hour 7-12 hours
 1-4 hours >12 hours
 4-7 hours > 24 hours

POSTPARTUM INFORMATION

Postpartum Visits:

| Postpartum Visits | Date & Place | Length of visit (hours) | Baby Feedings | Risk PP Depression / Referral | Key Focus of Visit |
|-------------------|--------------|-------------------------|---|--|--------------------|
| # 1 | | | <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referral | |
| # 2 | | | <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referral | |
| # 3 | | | <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referral | |
| # 4 | | | <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referral | |
| # 5 | | | <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referral | |

Special Needs and Information Given at the Postpartum Visits:

- | | |
|--|---|
| <input type="checkbox"/> Baby Care | <input type="checkbox"/> Emotional Recovery |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Mother/Infant Bonding |
| <input type="checkbox"/> Circumcision / Immunizations | <input type="checkbox"/> Patient Rights |
| <input type="checkbox"/> Communication with Care Provider(s) | <input type="checkbox"/> Physical Recovery |
| <input type="checkbox"/> Community Resources | <input type="checkbox"/> Other (<i>please specify</i>): |

Other Services Provided at the Postpartum Visits:

- | | |
|---|---|
| <input type="checkbox"/> Attended medical appointments for the Baby | <input type="checkbox"/> Other Children's needs |
| <input type="checkbox"/> Attended medical appointments for the Mother | <input type="checkbox"/> Translation (language) |
| <input type="checkbox"/> Household needs | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Care of Newborn | <input type="checkbox"/> Other (<i>please specify</i>): |

Referrals Made:

- | | | |
|--|--|---|
| <input type="checkbox"/> WIC | <input type="checkbox"/> Social Services | <input type="checkbox"/> Domestic Violence Shelter |
| <input type="checkbox"/> Social Work Services | <input type="checkbox"/> Medical Office | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Infant Support Services | <input type="checkbox"/> Health Department | |

Please rate the following interactions between mother and baby at the LAST Post Partum Visit. (on a scale from one to five with 1 being no interaction and 5 being the greatest):

Communication: 1 2 3 4 5

Touching and holding: 1 2 3 4 5

Affection: 1 2 3 4 5

Sensitivity to baby's needs: 1 2 3 4 5

Any difficulties with baby?

- Bathing Sleeping Feeding (wet diapers)
 Colicky Illness Weight Gain/Loss
 Other:

Evaluation of Doula Care Office Support:

Did you receive....?

Calls from the Volunteer Program Coordinator in a timely manner yes no

Resources that you needed yes no

Any other information that you needed yes no

Other comments:

Doula Experience

Please rate how you feel your presence affected your client's birth experience.

Strongly Negative 1 2 3 4 5 *Strongly Positive*

What do you feel was the best aspect of the birth experience for the mother and for yourself.

Please discuss what you feel was the worst aspect of the birth experience for the mother and for yourself.

Other comments:

For Office Use Only: Date Received _____

FOR PERSONAL USE (not for data collection)

Any unique issues or concerns that generated your client's referral to Doula's Care?

What are her expectations of you as her Doula?

Any additional information/features of her situation that relate to her potential birth experiences or parenting?