

DOULAS CARE – POSTPARTUM CLIENT INFORMATION FORM

Doula forms are available online as printable PDF files at www.center4cby.com.

Instructions for filling out this form:

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

- Call the client and set up your first postpartum visit ASAP.
- Provide postpartum services – as many as you have promised to the client.
- Administer the Edinburgh Postpartum Depression Scale at 3 weeks postpartum or at first visit if mother is at least 3 weeks postpartum. Call the Volunteer Coordinator to report scores of 10 or higher and she will assist you with follow-up. (Exception: Do not administer the scale if client has a medical diagnosis of postpartum depression at the time of referral.)
- 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 return phone calls for a period of time, we still need this form filled out as completely as possible and returned

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. Copy page 4 if you make more than 10 visits.

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 – POSTPARTUM CLIENT INFORMATION FORM

Doula's Name: _____

Client's Name: _____ Singleton Twins Triplets More _____

Address: _____ **Baby's DOB:** _____

Home Phone: _____ **Baby's Gender:** _____

Other Phones: _____ **Baby's Name:** _____

E-mail: _____

BACKGROUND INFORMATION:

Attended Childbirth Education Classes? no yes

Attended classes related to postpartum period or newborn care? no yes

Attended breastfeeding classes? no yes

Has client taken care of a newborn recently? no yes

Pregnancy: Normal
 Gestational Diabetes
 Pregnancy Induced Hypertension (PIH)
 High Risk because _____
 Other: _____

Pregnancy # _____ Birth # _____

Childbirth: Vaginal Episiotomy (degree _____)
 VBAC Tears/Lacerations (degree ____)
 Cesarean (Unexpected) Use of Forceps
 Cesarean (Planned) Use of Vacuum extraction
 Urinary catheter

Number of wks gestation at delivery: _____ Mother's total wt gain during pregnancy: _____

Baby's Birth Weight: _____ Length: _____

Baby's Outcome: Normal Stillbirth
 Premature Other: _____
 Birth defect

Breastfeeding: yes no *If yes, any formula supplementation?* yes no

Client's care provider and location:

Baby's care provider and location:

Does mother have a medical diagnosis of postpartum depression at the time of referral?

no yes

If yes,

Is she under a doctor's care? no yes

Is she under a therapist's care? no yes

Is she taking medication? no yes

Other approaches? _____

Comments? _____

Questions for the Doula

Names and relationships of partner and other support people who are helping during the postpartum period:

Names and ages of other children:

Does the family have any preferences for cooking or special dietary needs?

no yes

If yes, please describe:

Does the family have any particular religious or cultural traditions that they would like you to know? no yes

If yes, please describe:

Has the client or family experienced any stressful events, losses or major life changes in the past year? no yes

If yes, please describe:

Any additional information/features of her situation that relate to her recovery or parenting?

POSTPARTUM INFORMATION

At each postpartum visit, please consider: (1) Is the environment safe? (2) How is the mother doing? (3) How is the baby doing? Then note any areas of concern or needs below.

PP Visits	Date	Length of visit	Feeding	Summary of Primary Needs	Doula's Response
#1			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#2			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#3			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#4			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#5			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#6			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#7			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#8			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
#9			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		
# 10			<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both		

Did you administer the Edinburgh Scale?

- no yes

If yes, how many weeks postpartum was the mother when she took the test? _____

What was the score? _____

What, if any, action did you take? (Check all that apply)

- nothing at the time of visit
- made a mental note to keep an eye on her
- called the *Doulas Care* Volunteer Coordinator or Social Worker to discuss situation
- discussed my concerns directly with the mother
- discussed my concerns with partner or other support persons in the household
- shared information on postpartum depression
- shared information on community resources
- referred her to her healthcare provider
- other

Education/Support Given:

- Baby Care
- Breastfeeding
- Circumcision
- Communication with Care Provider(s) / Patient Rights
- Community Resources
- Emotional Recovery
- Immunizations
- Physical Recovery
- Other (*please specify*): _____

Services Provided:

- | | |
|---|---|
| <input type="checkbox"/> Attended medical appointments for the Baby | <input type="checkbox"/> Household needs/organization |
| <input type="checkbox"/> Attended medical appointments for the Mother | <input type="checkbox"/> Care of newborn(s) |
| <input type="checkbox"/> Translation (language) | <input type="checkbox"/> Other children's needs |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Errands |
| <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Breastfeeding counseling |
| <input type="checkbox"/> Laundry and light cleaning | |
| <input type="checkbox"/> Other (<i>please specify</i>): _____ | |

Did you make any referrals to community resources?

- no yes If yes, please check types of referrals made below.

Breastfeeding Support

- MSU Extension Services
- Hospital-based lactation consultant
- Private lactation consultant
- La Leche League
- Other: _____

Community Classes

- Breastfeeding
- CPR
- Infant Massage
- Mother/Baby Exercise
- Parenting
- Other: _____

Other Referrals

- Counseling services
- Domestic Violence support services
- First Steps program
- Free meals
- Medical care provider (midwife, OB)
- Pediatrician
- Pulic Health Department
- Social Services
- Support Groups: _____
- Used/free clothing and goods _____
- WIC
- Other (Please List): _____

Did Mother act on your referral and seek recommended help?

- no yes don't know
-

First Postpartum Visit

Please rate the following interactions between mother and baby.

(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

Please evaluate the enthusiasm of the new mother:

Low Enthusiasm 1 2 3 4 5 *High Enthusiasm*

Last Postpartum Visit

Please rate the following interactions between mother and baby.

(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

Please evaluate the enthusiasm of the new mother:

Low Enthusiasm 1 2 3 4 5 *High Enthusiasm*

Doula Experience

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

Strongly Negative 1 2 3 4 5 *Strongly Positive*

Please discuss what you feel was the best aspect of the postpartum experience for the mother and for yourself.

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

Please use the space below to add any thoughts/comments/suggestions or lessons learned from your entire experience with this family.

Do you have any suggestions for changes to the *Doulas Care Postpartum Program* design or services offered to families?

Are there any ways that we can help you be a better doula through continuing education programs that we might develop or offer? Be specific.

For Office Use Only: Date Received _____