Becoming a Mom® - Birth Outcome Card

Name: _____

BaM Participant ID #: _____

Name of baby: _____

Baby's Date of Birth: _____/_____/_____
(mm/dd/yyyy)

Date of Activity: _____/_____/_____
(mm/dd/yyyy)

Instructor/s Name:_____

What is the name of the hospital where you gave birth?

_____

At what gestational age was your baby born?
- Less than 32 weeks
- 32 to 36 weeks
- 37 to 38 weeks
- 39 weeks or after

What was your baby's weight at birth?
- Less than 3 lbs. 4 oz. (1500 grams)
- More than 3 lbs. 4 oz. (1500 grams) but less than 5 lbs. 8 oz. (2500 grams)
- 5 lbs. 8 oz. or more

Were you induced? (meaning your labor was started by your healthcare provider instead of starting on its own)
- Yes
- No

If you were induced, what was the reason?
- Medically necessary (Doctor ordered/suggested)
- Elective (at mother's request)
- Other
- Unknown

If "other", please explain:

_____

How was your baby delivered?
- Vaginally
- Cesarean

If by Cesarean delivery, what was the reason?
- Medically necessary (Doctor ordered/suggested)
- Elective (at mother's request)
- Unknown

Did you develop any medical conditions during your pregnancy?
- Yes
- No

If yes, please indicate the medical condition you developed:
- Gestational Diabetes
- Pre-term labor
- High blood pressure/pre-eclampsia
- Eclampsia (high blood pressure that causes seizures)
- Seizures (that are not caused by high blood pressure)
- Placenta Previa / Placental Abruption
- Anemia
- Depression/Anxiety
- Heart Disease
- Lupus / Other Auto-Immune Disease
- Other

Other medical condition:

_____

Have you had/scheduled your first postpartum check-up?
- Yes
- No, but I plan to
- I do not plan to schedule postpartum care

Where are you going/planning to go for postpartum care?
- Private Health Care Provider
- Public Health Clinic
- Military Provider
- Other
- Not currently receiving postpartum care

Would you like to become pregnant within the next year?
- Yes
- No
- Unsure
- Ok either way

Have you talked to your doctor about options for preventing pregnancy?
- Yes
- No

Are you using or do you plan to use any method to prevent pregnancy?
- Yes
- No

What method are you using/planning to use? (check all that apply)

- Diaphragm
- IUD (Intra-Uterine Device)
- Pill
- Natural Family Planning
- Condom
- Shot
- Arm Implant
- Tubal Ligation/Vasectomy
- Don't know
- Nothing
- Other

If other, please specify other contraceptive method:

_____

Are you taking prenatal vitamins or multi-vitamins containing folic acid?

- Everyday
- 4-6 times per week
- 1-3 times per week
- Not taking

I currently smoke ____ cigarettes per day.

- 0
- Less than ½ a pack
- ½ to a full pack
- More than a pack

Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits (If you smoked during your pregnancy, please check all that were done for you):

- Spending time with me discussing how to quit smoking
- Suggest that I set a specific date to stop smoking
- Suggest I attend a class or program to stop smoking
- Provide me with booklets, videos, or other materials to help me quit smoking on my own
- Refer me to counseling for help with quitting
- Ask if a family member or friend would support my decision to quit
- Refer me to a national or state quit line (like KanQuit)
- Recommend using Nicotine gum
- Recommend using a nicotine patch
- Prescribe a nicotine nasal spray or nicotine inhaler
- Prescribe a pill like Zyban (also known as Wellbutrin or bupropion) to help me quit
- Prescribe a pill like Chantix (also known as varenicline) to help me quit

Have you had/scheduled your baby's first check-up?

- Yes
- No

If no, what has kept you from scheduling your baby's first check-up?

- No doctor
- No insurance or any way of paying for it
- No transportation
- No childcare for my other children
- Other

If other, please describe other reason:

_____

What type of insurance do you have for your baby?

- Private insurance
- Medicaid (or have applied for)
- Tricare
- Don't have insurance
- Other

At birth, did your baby have any medical conditions/concerns which required NICU admission?

- Yes
- No

If yes, please indicate the conditions/concerns:

- Seizures or other neurological condition
- Heart condition
- Respiratory condition
- Feeding or weight gain concern
- Jaundice
- Low birth weight
- Prematurity
- Other

If other condition, please specify:

_____

_____

Are you currently breastfeeding your baby?

- Yes
- No

If no, did you nurse at all?

- Yes
- No

If yes, how long did you nurse?

- Only while in the hospital
- Less than one week
- One to six weeks
- More than six weeks

Are you using:
- Only mother's milk (breast or bottle)
- Both mother's milk and formula

Did any information that you learned in class change your mind about: (check all that apply)
- Whether to breastfeed
- How long to breastfeed
- Your confidence about breastfeeding
- None of these

I put my baby to sleep on his/her: (check all that apply)
- **Back**
- **Side**
- **Stomach**

My baby is put down to sleep: (check all that apply)
- **In a crib / bassinet or portable crib**
- **In an adult bed or couch or recliner with me**
- **In a car seat / carrier or bouncer or swing**

I ____talk(ed) about Safe Sleep with my child's other care providers (family members, childcare providers, etc.)
- **Have**
- **Plan to**
- **Do not plan to**

Please indicate whether you have or plan to contact the following community resources:

MCH Home Visiting (i.e. prenatal or postpartum visit in the home or other location by Health Department or BaM program staff) or other **Home Visitation Program Services**:
- Have contacted
- Plan to contact
- Do not plan to contact

Childcare Services (i.e. Childcare Aware, Health Dept. Childcare Licensing, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Substance Abuse Services:
- Have contacted
- Plan to contact
- Do not plan to contact

Medicaid/KanCare (i.e. application or eligibility specialist):
- Have contacted
- Plan to contact
- Do not plan to contact

Tobacco Cessation (i.e. KS Quitline, local resources, cessation program, or other on-line resources):
- Have contacted
- Plan to contact
- Do not plan to contact

Domestic Violence Prevention Services:
- Have contacted
- Plan to contact
- Do not plan to contact

Mental Health Services (i.e. Postpartum Support International, The Pregnancy & Postpartum Resource Center of KS, your OB provider, local counseling agencies and/or services, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Kansas Infant Death and SIDS Network (Safe Sleep information; Bereavement/Infant Loss Services, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Women, Infants, and Children (WIC) Services:
- Have contacted
- Plan to contact
- Do not plan to contact

Breastfeeding Support Services (help from local breastfeeding support staff, volunteers or support groups, La Leche League, etc.)
- Have contacted
- Plan to contact
- Do not plan to contact

Car Seat Installation:
- Have contacted
- Plan to contact
- Do not plan to contact

Parenting/Early Childhood Services (i.e. Parents as Teachers, Early Head Start, other local parenting programs and support services/Infant-Toddler developmental services, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Transportation (i.e. paid for through Medicaid provider, bus or other local transportation services, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Housing (i.e. Homeless shelter, Section 8, Housing assistance, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

Other Pregnancy Resources (i.e. Text-4-Baby, Count the Kicks, other local pregnancy services or childbirth classes, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

If "other pregnancy resource", please specify:

_____

Other (i.e. local food program/resources other than WIC, Cloth diapering resources, etc.):
- Have contacted
- Plan to contact
- Do not plan to contact

If "other" community resource, please specify:

_____