Becoming a Mom® - Birth Outcome Card

Name: _____

BaM Participant ID #: _____

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

Infant Birth Outcomes

Name of baby: _____

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

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)

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)

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:
- COVID-19
- Feeding or weight gain concern
- Heart condition
- Jaundice
- Low birth weight
- Low blood sugar
- Prematurity
- Respiratory condition
- Seizures or other neurological condition
- Other

If other condition, please specify:

_____

Are you currently breastfeeding your baby?
- Yes
- No

If no, did you breastfeed at all?
- Yes
- No

If yes, how long did you breastfeed?
- 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

If this Birth Outcome Card is for a subsequent baby in a multiple birth (i.e. the second of twins), please complete only the Infant Birth Outcomes section above. The Maternal Outcomes section must be completed once, but does not need to be completed with each additional baby.

Maternal Outcomes

Did you develop any health conditions during your pregnancy?

- Yes
- No

If yes, please indicate the health condition(s) you developed:

- Anemia
- Anxiety
- Cholestasis (liver condition occurring late in pregnancy)
- COVID-19
- Depression
- Eclampsia (high blood pressure that causes seizures)
- Gestational Diabetes
- High blood pressure
- Placenta Previa
- Pre-eclampsia
- Pre-term labor (going into labor before 37 weeks gestation)
- Seizures (that are not caused by high blood pressure)
- Substance Use Disorder or Relapse (inability to control the use of a legal or illegal drug or medication, alcohol, or nicotine)
- Other

If other, what other health condition did you develop?

_____

Which of the following are POST-BIRTH Warning Signs? (check all that apply)

- Pain in chest
- Obstructed breathing or shortness of breath
- Seizures
- Thoughts of hurting myself or someone else
- Night sweats without a fever
- None of the above

I should do the following if I am experiencing POST-BIRTH Warning Signs: (check all that apply)

- Call 911 if I am experiencing URGENT or life-threatening POST-BIRTH Warning signs
- Call my health care provider (or go to the ER if I cannot reach my provider) if I am experiencing other POST-BIRTH Warning signs
- Always trust my instincts and get medical care if I am not feeling well or have concerns
- Tell 911 or my healthcare provider that I was recently pregnant
- None of the above

Who of the following has discussed the POST-BIRTH (Maternal) Warning Signs with you? (select all that apply)

- ○ Prenatal care Provider (Dr. or Nurse Midwife)
- ○ Nursing staff at my prenatal care provider's office
- ○ Home visitor
- ○ Prenatal class instructor
- ○ Nursing staff at the birth facility I delivered in
- ○ WIC staff
- ○ Family Planning staff
- ○ Doula
- ○ Other health educator
- ○ I did not receive this education from anyone
- ○ Other
  If "other" please explain:

  _____

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

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/vape ____.

- ○ 0
- ○ Less than ½ a pack of cigarettes per day
- ○ ½ to a full pack of cigarettes per day
- ○ More than a pack of cigarettes per day
- ○ I vape or use tobacco products other than cigarettes in the following quantity (please describe the product you use and how much you use):

  _____