

Which Caregiver/Adult was involved (Client Name)?

Date of Activity: ____/____/____

**Attended at least one postnatal care visit? (medical
checkup 4-6 weeks postnatally)**

- Yes
- No

Date of infant birth: ____/____/____

Gestational age of infant at birth (in weeks)

- <32 weeks
- 32-37 weeks
- >37 weeks

Multiple Birth? (skip if not a multiple birth)

- Yes

**Infant received one-week visit to pediatrician/
doctor?**

- Yes
- No

Infant placed for adoption?

- Yes
- No

If yes, Date of adoptive placement:

____/____/____

Age of mother at time of adoptive placement:

Fetal/Infant death?

(Select one)

- Yes
- No