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)

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 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)
- ☐ 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?

_____

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

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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:

- ☐ 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**

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

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

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

If "other" community resource, please specify:

_____