

POSTPARTUM QUESTIONNAIRE/ AUTHORIZATION FOR POSTPARTUM EMOTIONAL SUPPORT PROGRAM/POSTPARTUM DEPRESSION RISK ASSESSMENT

Patient Name _____

DOB _____

MRN _____

Physician _____

FIN _____

POSTPARTUM QUESTIONNAIRE

Baby blues and postpartum depression are very common in the first few weeks and months after delivery. This questionnaire will help us tell if you have an increased risk of having any postpartum adjustment difficulties. If we see that you may be at risk, a nurse may visit you in the hospital and may call you at home to see how you are doing and offer suggestions that could help make this easier. Your completed questionnaire will be placed in your medical record and a copy may be forwarded to your health care providers.

Respond to the following confidential statements as honestly as you can.

YES NO

1. My immediate family has a history of depression, anxiety, or mental health problem.
2. During the past year, I have experienced a lot of negative stress and change (example: loss of job, loss of loved one, undesired move, etc.)
3. This was a **very** difficult pregnancy for me emotionally and/or physically.
4. This was a **very** difficult birth for me emotionally and/or physically.
5. I have a history of an emotional problem (depression/anxiety/abuse/eating disorder, etc.) that was **not** related to childbirth that may have been treated with counseling or medication.
6. I had depression or anxiety in the weeks/months following the birth of another child or pregnancy loss.
7. I often feel unloved and unsupported by those around me.
8. I have taken medication for depression, anxiety, or bipolar disorder **during** this pregnancy.
9. During this pregnancy I have had some **very** disturbing feelings or thoughts.
10. I am currently having difficulty with depression, anxiety, anger, or frightening thoughts. I may look happier on the outside than I feel on the inside.
11. I have thoughts of hurting myself and/or my baby, and am afraid that if I tell someone how I feel they will not understand or they will think something is really wrong.

- My baby is in the Neonatal ICU I have delivered a multiple birth
- I would like to request more information about Postpartum Emotional Support regardless of the outcome of this assessment

Where I can be reached after I leave the hospital:

Patient name (print) _____

Home phone _____ Cell phone _____

Address _____ City _____ State _____ Zip _____

Nearest friend or relative's name _____ Phone _____

Date of baby's birth _____ Baby's doctor _____

Name of your doctor/midwife/clinic _____

AUTHORIZATION

By signing this you are giving permission to share results with your care providers and to receive follow up phone calls.

Patient signature _____ Date _____

Thank you for completing this questionnaire. **Return it to your nurse** so it can be reviewed before you leave the hospital. This data will be used to assess the type of services you receive.

STAFF USE ONLY

RISK ASSESSMENT

- Risk status _____
- Nurse visit _____ (date)
- Referral _____

Date _____ Time _____ Staff signature _____

White — Chart Yellow — Care Provider

DO NOT MARK BELOW THIS LINE

BARCODE ZONE

DO NOT MARK BELOW THIS LINE

