

British Columbia Community Maternal Assessment Checklist

HEALTH CENTRE/HEALTH AUTHORITY

SURNAME	GIVEN NAME(S)	DATE OF BIRTH: (maternal)	year	month	day	TELEPHONE NUMBER
NEWBORN SURNAME (if different from maternal)		NEWBORN BIRTHDATE	year	month	day	time

OUTCOME CODES ✓ - No apparent problem * **OBS** - Observe * **TRP** - Under treatment * **UNR** - Unresolved
 X - Not assessed * **REF** - Referral * **TRC** - Treatment complete Y - yes N - No

*Those items with an * asterisk require a narrative explanation on the Variance Record.*

Date (y/m/d)				
Time (24 hour clock)				
P.P Hours (utilize hours to 96 h, then utilize number of days)				
Contact Type (HV = Home Visit TC = Telephone Call OV = Office Visit FV = Facility Visit)				

Assessment Items

Psychosocial Items

Activities / Rest				
Attachment				
Emotional Status				
Family Function				
Family Planning / Sexuality				
Health Follow-up				
Lifestyle				
Support Systems / Resources				

Physiological Items

Breasts					
Abdomen / Fundus					
Perineum					
Lochia					
Elimination					
Nutrition					
Vital Signs	Temp / Pulse				
	Resp / BP				
Other Needs / Concerns (specify):					

SIGNATURE OR INITIAL

--	--	--	--

Family file opened:

Yes

No

