Community Action of Southeast Iowa
Early Head Start/ Education Component
POSTnatal Home Visit of Summary/Checklist

Mother's Name: _____Date:_____

Family Member's Present _____

Home Visit Location &/or Results
_____ On Site
_____ Client's Home
_____ Other Site (specify) _____
_____ No Show

Visit Time Frame
Start Time:_____
End Time:_____

Mark best way to communicate with family:
_____Telephone
_____Personal Contact
_____Notes
_____Other: _____

Baby's Name:_____ (boy or girl)

Delivery Date: _____

Baby's height_____ and weight_____

Delivery Location:_____

Delivery Type:_____ Any Complications?_____

Who will be the Baby's Doctor?_____

Do you plan to breastfeed or bottlefeed? (circle one)
How is it going?_____

How is Mom feeling/doing?_____

_____

Any questions or concerns?_ _____

Does Mom have all that she needs?_____

Date of first Home Visit_____

When does Mom plan to return to work or school?_____

Is there a backup plan for childcare?_____

Staff Signature_____

Participant Signature_____

Date: _____

Copy to: _____ Mother's file _____ Supervisor

DC 7/13