Postpartum Care Plan

PATIENT INFORMATION

Date: _____ dd / mm / yyyy

Patient Name: _____

Date of Birth: _____ dd / mm / yyyy

Physician: _____

Gestational Age: _____

Delivery Date: _____ dd / mm / yyyy

Address: _____

Contact: _____

Emergency Contact: _____

PHYSICAL RECOVERY

Incision/Wound Care

Pain Management

Perineal Care

Activity Level

EMOTIONAL WELL-BEING

Postpartum Depression/Anxiety Screening

Support System

Self-care

NUTRITION AND HYDRATION

Hydration

Nutrition

BREASTFEEDING

Latching and Positioning

Frequency and Duration

Engorgement Management

FOLLOW-UP CARE

Postpartum Visit

Contraception

EMERGENCY CONTACT INFORMATION

Obstetrician/Midwife: _____ Hospital/Clinic: _____

Emergency Services