Certification: Postpartum

WIC ID: _____ **Name:** _____

Cardholder: _____ **Today's date:** _____

Weight: ____ **Height:** ____ **Total prenatal weight gain:** _____ **Delivery date:** _____

Hgb/Hct: _____ **Twins or more:** ❑ Yes ❑ No

The format of the questions follows what is seen in TWIST.

Note: Bolded questions are mandatory TWIST questions

Health History

01 Tell me about your labor and delivery.

01.5 How would you describe your health?

03 For the pregnancy just completed, how many babies did you have? (335)

❑ One

❑ Two

❑ Three

❑ Four or more

04 Did you have a cesarean delivery? (359)

❑ No

❑ Yes, less than 2 months ago

❑ Yes, more than 2 months ago

05 Was your baby born at or before 38 weeks gestation? (311)

❑ No ❑ Yes

06 What was your baby's birth weight? (312, 337) _____ Pounds _____Ounces

❑ Between 5#8oz and 9#

❑ Less than or equal to 5#8oz

❑ More than or equal to 9#

07 Do you now or during your pregnancy did you have any health conditions or medical problems? (300+)

❑ No

❑ Yes (please describe)

08 Do you take any medications now? (357)

❑ No

❑ Yes, but no nutritional impacts

❑ Yes, there are drug-nutrient interactions

Medication(s):

09 Are you currently smoking cigarettes or vaping? (371)

❑ No

❑ Yes – referral made. What type and how often?

10 Have you been in an enclosed space while someone was smoking cigarettes or vaping? (904)

❑ No ❑ Yes

11 Do you drink 8 or more servings of alcohol/week or 4 or more servings/day? (372)

❑ No ❑ Yes – referral made, describe:

12 Have you used any drugs since delivery? (for non-BF, drugs other than marijuana) (372)

❑ No ❑ Yes - referral made, describe:

13 Do you have any concerns about your safety at home or in your relationships? (901)

❑ No

❑ Unable to ask

❑ Yes

Diet Assessment

01.1 Since having your baby, what meals, snacks, beverages do you typically have?

02.1 How would you describe your appetite?

02.5 In the past few months, were there times when your family ran low on food?

❑ No ❑ Yes

03.1 How do you feel about the weight changes you have experienced since delivery?

04.1 What foods, if any, do you avoid for health or other reasons?

05.1 Are you on a low calorie or restricted diet? (427.2)

- ❑ No
- ❑ Vegan
- ❑ Macrobiotic
- ❑ Low Carbohydrate/High Protein
- ❑ Other:

06.1 Do you eat anything that is not food? (427.3)

❑ No ❑ Yes, describe:

07.1 What vitamins or other supplements do you take? (427.4)

- ❑ Vitamin or supp with folic acid
- ❑ None or supp without folic acid
- ❑ Unknown

NE Provided:

Next Step:

Food Package Notes: (modifications, etc)

Quarterly NE Plan/Next Appointment Type: