

Postpartum Care Notification Form



To qualify for the incentive:

- Complete this form and **fax to California Health & Wellness** within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, certified nurse midwife, or licensed midwife.
- The postpartum visit must be between three and eight weeks (21 to 56 days) after delivery.
- This form must be kept in the patient's medical record.

Fax to: 1-877-783-0287

Date of postpartum visit: _____

Member Information

First name:					Last name:				
Medi-Cal ID # (CIN #):					Date of birth:				
9					Telephone number:				
Address:					City:			ZIP code:	

Primary Language

English
 Spanish
 Vietnamese
 Mandarin
 Farsi
 Korean
 Arabic
 Other: _____

Postpartum Assessment

Date of delivery: _____ Hospital: _____

<input type="checkbox"/> Confirmation of live birth		BP: _____	Weight: _____
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments:	
Breasts	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Breastfeeding	Comments:	

OR

Pelvic	Uterus: _____ Cervix: _____ Other comments: _____	Pap test: (optional) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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Additional comments/visit notes:

Provider Information

Practitioner name:		Clinic name:	
Practitioner NPI:	Specialty (OB/GYN, PCP, NP, or CNM):	Clinic address:	
Office contact name:		City:	County:
Office telephone number:		ZIP code:	

I confirm that this document is filed in the member's legal health/outpatient record.

Practitioner signature:	Date signed:
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