2E

FORM 2E: Health Plan Implementation for MATERNAL HEALTH: POST-PARTUM CARE

Part 1: HEALTH RISK ASSESSMENT & KEY HEALTH MESSAGES (Indicate Y, if 'yes'; N if 'no')

E1 . Were you checked by a doctor, nurse or midwife immediately after giving birth (postpartum)? _____

(Deliver the Message for E1 then go to Question E2)

Message for E1

- Complications may arise within 42 days after delivery. You are at risk. Visit your health provider to detect and treat possible complications following these schedules:
  - Within 12 hours after delivery
  - On the 3rd day
  - On the 7th day
- If you have not visited a health provider 7 days after delivery, go for postpartum check-up immediately

E2. Are you experiencing any of the following danger signs? *(please check)*

- ☐ Difficulty breathing
- ☐ Paleness
- ☐ Severe headache
- ☐ Fever
- ☐ Foul-smelling vaginal discharge
- ☐ Difficulty in urinating
- ☐ Severe vaginal pain
- ☐ Engorged and painful breast
- ☐ Heavy vaginal bleeding

(Deliver Message for E2 then go to Part 2)

Message for E2

- If you are experiencing any of these danger signs, go to the nearest health facility immediately
- If you are a PhilHealth member or dependent, bring your PhilHealth card and Member Data Record (MDR)

For more information, see the "Family Health Guide, A. Messages: Caring for Mothers After Giving Birth", p. 13

Part 2: GENERAL INFORMATION (to be filled out with the help of the CHT partner)

Name of Respondent (Last name, first name, mother's maiden name)	NHTS HH ID: ☐☐☐☐☐☐☐☐☐–☐☐☐☐–☐☐☐☐☐
Name of CHT partner (Last name, first name, mother's maiden name)	Date of Visit when Health Plan was developed (mm/dd/yy):

Part 3: HEALTH PLAN (to be filled out with the help of the CHT partner)

3.1 Plan for **REGULAR** Cases

Health Goal	Referral Provider/s (name and address) (use the list of health providers in the Family Health Guide)	Date of planned visit (mm/dd/yy)
☐ To receive post-partum care within 12 hours, 3 days and 7 days after delivery		
☐ Others		

3.2 Plan for **EMERGENCY** Cases (Please fill up if there is a check in any item in E2 or any other source of alarm)

Reasons for Emergency Referral	Emergency transport providers **(name and contact no.)**	Health Service Providers **(name and address)** Refer to List of Health Providers
☐ Consultation for immediate assessment and management of danger signs		

I/we understand the health risks and needs of our family and I/we have decided to develop this health plan.

_____
(Name and signature of respondent)

Part 4: ACTIONS TAKEN (to be filled out by the midwife, nurse or doctor

Name and address of health provider:

Services provided: (*Please include procedures, medications, advice given.*)	Date of consultation (mm/dd/yy): Schedule of next check-up(mm/dd/yy):

Instruction of the provider:

Part 5: Service Utilization and Monitoring Form for MATERNAL HEALTH (POST-PARTUM)				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)

Part 5: Service Utilization and Monitoring Form for MATERNAL HEALTH (POST-PARTUM)				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)