Abbreviated template

Patient name: @PTNAME@
MRN: No patient ID available
Age: No DOB on File.
Gestational age: @GA@
Estimated delivery date: @EDD@
Prenatal care provider
Name: ***
Phone: ***
Office address: ***
PCP: ***
Mental health provider: ***
Lactation consultant: ***

Postpartum follow up visit
Time: ***
Date: ***
Location: ***
Number: ***

Initial postpartum planning session provided {YES(DEF)/NO:20626}

Discussed {postpartum topics:51769}
Management for postpartum physical recovery provided {YES(DEF)/NO:20626}
Discussed warning signs including {warning signs:51834}

Provided anticipatory guidance for lactation difficulties and where to seek assistance including nurses and lactation consultants {YES(DEF)/NO:20626}
Breast pump ordered {YES(DEF)/NO:20626}

Postpartum contraception counseling provided {YES(DEF)/NO:20626}
Postpartum contraception plan ***
Contraception {AMB CCC CONTRACEPTION - FEMALE:26309}

Maternal complications during pregnancy or delivery {YES(DEF)/NO:20626}
If yes, list: ***
Follow up for complications YES(DEF)/NO:20626}
Pending test results ***

Postpartum depression screening performed {YES(DEF)/NO:20626}
Educated patient on {PPD counseling:51757}
Management for postpartum psychiatric conditions provided {YES(DEF)/NO:20626}

Treatment plan

Medical

***

Psychiatric

***

Referrals provided

***

Follow up

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