POSTNATAL DISCHARGE FORM

Name of Health Facility: _____ Department: Maternity / Postnatal Ward

Hospital Registration Number: _____ Date of Admission: _____ Date of Discharge: _____

A. MATERNAL INFORMATION

Full Name: _____ Age: _____ Address / Contact: _____
Gravida: _____Para: _____ Abortions: _____ Gestational Age at Delivery: _____ weeks
Date and Time of Delivery: _____
Mode of Delivery: ☐ Spontaneous vaginal delivery ☐ Assisted vaginal delivery ☐ Caesarean section
Indication for Caesarean Section (if applicable): _____ ANC Registration Number:_____

B. MATERNAL CONDITION AT DISCHARGE

General Condition: ☐ Good ☐ Fair ☐ Unstable Blood Pressure: _____ mmHg
Pulse Rate: _____ bpm Temperature: _____ °C Respiratory Rate: _____ breaths/min
Uterine Involution: ☐ Normal ☐ Abnormal Lochia: ☐ Normal ☐ Excessive ☐ Foul-smelling
Perineum / Surgical Wound: ☐ Normal ☐ Healing ☐ Complicated ☐ N/A Bowel Function: ☐ Normal ☐ Abnormal
Breast Condition: ☐ Normal ☐ Engorged ☐ Cracked nipples Urination: ☐ Normal ☐ Difficulty Bowel Function: ☐ Normal ☐ Abnormal Haemoglobin (if indicated): _____ g/dL
Maternal Diagnosis / Complications:

C. NEWBORN INFORMATION

Baby's Name: _____ Sex: ☐ Male ☐ Female Date and Time of Birth: _____
Birth Weight: _____ kg Discharge Weight: _____ kg Discharge Weight: _____ kg
APGAR Score: 1 minute _____ 5 minutes _____ Feeding: ☐ Breastfeeding ☐ Other: _____Baby's Condition: ☐ Good ☐ Requires further care Cord: ☐ Clean and dry ☐ Abnormal
Z
Immunizations Given: _____Other Preventive Interventions: _____
Newborn Screening / Tests: _____
Newborn Diagnosis / Complications:

D. TREATMENT AND MEDICATIONS ON DISCHARGE

Medication	Dose	Route	Frequency	Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. HEALTH EDUCATION PROVIDED

Tick the topics discussed with the mother: ☐ Exclusive breastfeeding ☐ Maternal nutrition and personal hygiene ☐ Perineal or Caesarean wound care ☐ Perineal or Caesarean wound care ☐ Perineal or Caesarean wound care ☐ Family planning and birth spacing ☐ Maternal danger signs☐ Newborn danger signs ☐ Cord care ☐ Immunization schedule ☐ Postnatal follow-up appointments

F. DISCHARGE PLAN

Maternal Condition: ☐ Fit for discharge ☐ Referral ☐ Further observation
Date of Next Maternal Postnatal Visit: _____ Date of Next Newborn Visit: _____Referral Facility (if applicable): _____Referral Facility (if applicable): _____
Special Instructions_____

G. DISCHARGE AUTHORIZATION

Discharging Clinician / Midwife: _____ Designation: _____

Signature: _____ Date: _____ Mother's / Guardian's Name: _____

Mother's / Guardian's Name: _____ Signature / Thumbprint: _____