Newfoundland and Labrador Healthy Baby Club

Resource Mother _____

GETTING TO KNOW THE MOM **Part A**

***reminder – before starting, discuss consent, confidentiality, and privacy with the participant.**

Participant Name _____ HBC Site _____

Date of Interview _____

Address _____ Email _____

_____ Postal Code _____

Phone # _____ Cell # _____

Emergency Contact (Name and Relationship to Participant) _____

_____

Address if different from above _____

Phone if different from above _____

Age _____

Due Date _____
(MM/DD/YYYY)

Date of Entry in HBC _____
(MM/DD/YYYY)

Weeks Gestations at entry into HBC _____ weeks (1st ___ 2nd ___ 3rd ___Trimester)[1]

Date Food Supplements began _____
(MM/DD/YYYY)

Do you have a family doctor? ☐ Yes ☐ No

If yes, what is your doctor's name? _____

Have you seen your doctor since you have become pregnant? ☐ Yes ☐ No

If no, have you seen a health care provider such as a nurse practitioner, mid-wife, or public health nurse? ☐ Yes ☐ No

If yes, what is your health care provider's name? _____

[1] 1st Trimester weeks 0 - 12 2nd Trimester weeks 13 - 27 3rd Trimester weeks 28 - 42

The following questions on this page are collected for statistical purposes. The information is used for national and provincial reports. It does not identify you as an individual. You can choose not to answer any of the questions.

1. Why did you choose to come to Healthy Baby Club? (Please check all that apply.)

☐ To learn about a healthy pregnancy
☐ To learn about eating healthy during pregnancy
☐ To learn about breastfeeding
☐ To meet other women/moms/teens
☐ To get food supplements
☐ Other _____

2. Who referred you to Healthy Baby Club?

☐ Self-referred
☐ Health care professional (e.g. nurse, nutritionist, doctor)
☐ Friend
☐ Mother Baby Nutrition Program
☐ HBC participant
☐ Other _____

3. Are you a Canadian citizen?

☐ Yes
☐ No
Where were you born? _____

How long have you lived in Canada? _____

4. If Indigenous participant, indicate:

☐ First Nations – Status/Non-Status
☐ Metis
☐ Inuit
☐ Other _____

5. What language do you use most often at home?

☐ English
☐ French
☐ Other (please specify) _____

6. What is the highest level of education you have completed?

☐ Some high school
☐ Completed high school
☐ Some post-secondary
☐ Completed post-secondary

7. About how much is your total <u>monthly</u> family income before taxes? (Please include all kinds of income such as income from work, income support, child benefits, family allowance, child support payments and other benefits.)

☐ Less than $1,250
☐ $1,251 - $1,670
☐ $1,671 - $2,500
☐ Over $2,500
☐ Do not know
☐ Choose not to answer

8. Including you, how many people does this income support? _____
☐ Choose not to answer

Mother Baby Nutrition Supplement

When women are pregnant and have low income, they are eligible for the Mother Baby Nutrition Supplement.

1. Do you know about the MBNS? ☐ Yes ☐ No
   If yes, have you already applied? ☐ Yes ☐ No
   If no, would you like to apply? ☐ Yes ☐ No

Mother Baby Nutrition Supplement 1-800-508-4788 or www.hrle.gov.nl.ca/hrle/income-support/nutritionsupplement.html

2. Do you have a drug card? ☐ Yes ☐ No

Newfoundland and Labrador Prescription Drug Program -1-888-858-3535 or www.health.gov.nl.ca/health/prescription/index.html

If you have a drug card, the recommended prenatal vitamin/mineral supplement is available free of charge with a prescription from your doctor.

3. Are you currently taking a prenatal vitamin/mineral supplement or any other supplement?

☐ Yes ☐ No

4. If yes, what are you taking? _____

Weight History

1. Do you have questions or concerns around healthy weight gain during pregnancy?

□ Yes □ No

2. Would you like a referral to a nutritionist? □Yes □No

Pregnancy History

1. Have you ever been pregnant before? □Yes □No

2. How many times have you been pregnant, including this pregnancy? _____

3. Did you have any health problems with any of your previous pregnancies (e.g. High blood pressure, diabetes, etc.)?

_____

Pregnancy Health History

1. Tell me how you have been feeling during this pregnancy? *Carefully listen and discuss how they are dealing/coping with such things as nausea, vomiting, heartburn, tiredness or any other discomfort. For example, "Some women have trouble with constipation while pregnant. Is this a concern for you?"*

2. Is there anything else I should know about how you are feeling?

Chronic Health Problems

1. Do you have any existing health problems that you would like to discuss? *(e.g. diabetes, high blood pressure, anemia, bowel problems, eating problems, allergies (including to foods), mental/emotional health issues)*

☐ Yes ☐ No

2. What has your doctor said about this? _____

3. Are you on a special diet or do you have dietary restrictions? (e.g. low salt, low fat, diabetic, food allergy).

☐ Yes ☐ No

If yes, please describe. _____

4. Does this impact the food supplement? ☐Yes ☐No

Lifestyle

Drugs 

1. Are you taking any prescription drugs? ☐ Yes ☐ No
If yes, please list. _____

2. Does the doctor, who prescribed the drug for you, know that you are pregnant?

☐ Yes ☐ No

If no, let your doctor know that you are pregnant.

3. Are you taking any drugs that a doctor did not prescribe, or someone gave to you, or you bought at the store? (e.g. Tums or Rolaids, Aspirin or Tylenol, cold or herbal remedies)

☐ Yes ☐ No

If yes, please list. _____

_____

4. Does your doctor know that you are taking these drugs? ☐ Yes ☐ No
If no, let your doctor know you are taking these drugs.

Smoking 

1. I have some information about smoking in pregnancy and second-hand smoke during pregnancy. Is this something that you would like to discuss further?
☐Yes ☐No
If no, we can discuss this at any time in the future.

If yes, refer to the Helping Women Live Smoke-free Toolkit for information and resources to share with the woman and continue with the following questions:

Follow the Helping Women Live Smoke-Free Screening Tool for Tobacco Use: Ask, Advise, Refer.

2. Are you currently smoking? ☐Yes ☐No

3. If yes, have you thought about quitting? ☐Yes ☐No

4. Did you recently quit? ☐Yes ☐No

5. Would you like to have support to quit? ☐Yes ☐No

I can refer you to your Public Health Nurse or to the NL Lung Association Smokers' Helpline. The Helpline is a free, local service that is confidential. I can refer you to the Helpline or you can also call the helpline yourself or check it out online at www.smokershelp.net or Call **1 800 363 5864** or Text **709 700 7002.**

6. Do others smoke around you? ☐Yes ☐No

It is important to avoid second-hand smoke as much as possible. There is no safe level of second-hand smoke. I can provide you with some information.

Alcohol 

1. I have some information about alcohol and pregnancy. Is this something you would like to discuss further? Would you like to be provided with a pamphlet?
☐Yes ☐No

If no, we can discuss this at any time in the future.

2. Would you like support or a referral to reduce your alcohol intake?*only ask this question if the answer to the above is YES

☐Yes ☐No

Systems Navigator (available to help people navigate the mental health and addictions system in NL) 1-877-999-7589

Cannabis 

1. I have some information about cannabis and pregnancy. Is this something you would like to discuss further? Would you like to be provided with a pamphlet?

☐Yes ☐No

If no, we can discuss this at any time in the future.

Drugs 

1. Are you or anyone in your family affected by drug use (eg. Opioids, methadone, etc.)? Would you like to discuss this further? Would you like to be provided with a pamphlet?

☐Yes ☐No

If yes, please explain _____

_____

2. Would you like support or a referral to reduce your drug intake? *only ask this question if the answer to the above is YES

☐Yes ☐No

Systems Navigator (available to help people navigate the mental health and addictions system in NL) 1-877-999-7589

Support

1. Who do you turn to most when you need help? (e.g. partner, friend, mother or other relative)

_____

2. Now that you are pregnant, who do you rely on for emotional support?

_____

3. Would you like someone to come with you to the Healthy Baby Club group sessions?

☐ Yes ☐ No Comment _____

4. During pregnancy many women have concerns about different things. Tell me about the things that concern you. *(Encourage mother to talk about concerns first and then follow through with the list if nothing is mentioned.)*

_____

5. The following is a list that describes concerns that some women have during pregnancy. Tell me how you feel about these. *You may pass this to the participant to complete

	0 Not at all concerned	1 Somewhat concerned	2 Concerned	3 Very concerned
Pregnancy	☐	☐	☐	☐
Labour and Birth	☐	☐	☐	☐
Parenting	☐	☐	☐	☐
Transportation	☐	☐	☐	☐
Clothing	☐	☐	☐	☐
Money/Budgeting	☐	☐	☐	☐
Food	☐	☐	☐	☐
Family Support	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Abuse	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Child Care	☐	☐	☐	☐
Addictions (you or someone else)	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐
Other	☐	☐	☐	☐

Of the concerns that you have mentioned, what do you feel are your biggest?

1. _____ 2. _____ 3. _____

Would you like me to help with or make a referral on any of these concerns?

☐Yes ☐No

Relaxation Time and Physical Activity

1. Tell me about the things you like to do in your free (relaxation) time. *(eg. watching T.V., computers, reading, crafts, getting together with friends, meditation, gardening)*

2. Tell me about the things you do for physical activity. *(eg. walking, running, swimming, skating)*

3. How many times a week do you do these physical activities for at least 20 minutes?
☐ Never ☐ Once a week ☐ Twice a week ☐ 3 or more times a week

4. Is this the same level of physical activity you get now that you are pregnant?
☐Yes ☐No

Nutrition
The next few questions are about your eating habits and cooking.

1. Tell me about the foods you usually eat.

2. Are there any foods that you really dislike or disagree with you?

3. When you eat at home, how many people usually eat with you?

4. Who usually does the cooking?

5. Do you enjoy cooking? ☐Yes ☐No

Comment – what types of things do you like to cook?

6. Do you know about Canada's food guide? Do you follow the guide most days?
☐Yes ☐No

7. How often do you eat out or eat pre-packaged meals per week? (e.g. microwave dinners/frozen pizza, fast food)

8. Do you sometimes run short of food? ☐Yes ☐No

Comment

9. Do you know about the food bank in/nearest to your community? (if applicable)
☐Yes ☐No

10. Do you see it as a help to you? ☐Yes ☐No

Comment _____

11. Do you need help with food budgeting? □Yes □No

Feeding Baby 

1. Have you breastfed before? □Yes □No

2. Have your family or friends had any experience with breastfeeding? □Yes □No

3. Are you thinking about breastfeeding your baby? □Yes □No

4. Would you like more information around infant feeding? ***OR*** Do you have any questions or concerns about infant feeding?

_____

5. And finally, tell me what you want most out of the Healthy Baby Club? _____

_____

_____

_____

_____

_____

_____

_____

_____

This section to be completed after the interview by the Resource Mother

Concerns identified _____

_____

_____

_____

_____

_____

_____

Plans for follow-up with Public Health Nurse, Regional Nutritionist, Coordinator (specify)

_____

_____

_____

_____

_____

_____

_____

Referrals to other professionals or agencies_____

_____

_____

_____

_____

Eligibility into Healthy Baby Club (choose all that apply)

- ☐ low income
- ☐ living in stressful or violent situations
- ☐ no other prenatal services available
- ☐ other _____
- ☐ abuse of alcohol or other substances
- ☐ living in isolation (no social supports)
- ☐ adolescent

Resource Mother _____ Date _____

HEALTHY BABY CLUB OUTCOMES Part B

To be completed at the end of the mother's participation in Healthy Baby Club.

Date of home visit after birth of baby _____
(MM/DD/YYYY)

Date of Exit from Healthy Baby Club _____
(MM/DD/YYYY)

Did the mother complete the Healthy Baby Club program? ☐ Yes ☐ No

If no, please outline the reason(s).

_____

_____

Birth Outcomes

Date of Birth _____ Number of weeks gestation _____ weeks
(MM/DD/YYYY)

Live Birth ☐ Yes ☐ No

Type of Delivery ☐ Vaginal ☐ C/S

Birth Weight _____ Length _____

Head Circumference _____

Length of hospitalization of mother and baby after the birth _____ days

Mom's total weight gain during pregnancy _____

Food Supplements

Date food supplements ended _____
(MM/DD/YYYY)

Prenatal Period

Number of weeks of food supplements: prenatal _____ weeks

Were any food substitutions given? ☐ Yes ☐ No

If yes, identify what was given. _____

_____

Postnatal Period

Number of weeks of food supplements: postnatal _____ weeks

What food supplements were given during the postnatal period? _____

_____

Lifestyle During Pregnancy

What changes were made in your lifestyle during this pregnancy?

Eating Patterns

☐ I ate well prior to pregnancy ☐ I ate healthier during my pregnancy ☐ I ate less healthy during my pregnancy

Level of Physical Activity

☐ I was active prior to pregnancy ☐ I became more active during my whole pregnancy ☐ I was less active during my whole pregnancy

Smoking

☐ Did not smoke prior to pregnancy ☐ No change in smoking habits
☐ Reduced ☐ Stopped ☐ Increased

Alcohol

☐ Did not drink prior to pregnancy ☐ No change in drinking habits
☐ Reduced ☐ Stopped ☐ Increased

Street Drug Use

☐ Did not use prior to pregnancy ☐ No change in drug habits
☐ Reduced ☐ Stopped ☐ Increased

On a rating scale of "Agree", "Somewhat agree" or "Disagree" how would you rate the following questions?

HBC helped me learn more about healthy eating.	☐ Agree	☐ Somewhat Agree	☐ Disagree
HBC helped me learned the importance of physical activity for me and my family.	☐ Agree	☐ Somewhat Agree	☐ Disagree

Are there needs that were not met by Healthy Baby Club ☐Yes ☐No
If yes, what were the unmet needs? _____

_____

Postnatal Information

Was the baby discharged home with the mother? ☐ Yes ☐ No
Comment _____

Did the mother initiate breastfeeding? ☐ Yes ☐ No
How long did you breastfeed?

1-7 days ☐
1 to 4 weeks ☐
1 to 3 months ☐
3 to 6 months ☐
Breastfeeding continued at program exit. ☐

Did you supplement your breastfeeding with formula feedings or other liquids/foods? ☐ Yes ☐ No

If yes, what type of supplement(s) did you use? _____

If breastfeeding has stopped, please check from the list below the answer that best represents the reason why breastfeeding was discontinued.
Note: the list should not be read to the mom as it may bias her response. You should ask the mom why she stopped breastfeeding and match her response.

Reasons for Discontinuing Breastfeeding	**Indicate by check mark**
CONCERNS WITH SUPPLY Not enough milk/ Baby not gaining weight/ Baby not satisfied	
ISSUES WITH LATCHING Pain/ Soreness /Discomfort Tongue Tie / Cleft lip/palate Inverted nipples Poor technique/poor latch	
MOTHER BABY SEPERATION Baby or Mom Sick or Hospitalized Custody issues/Baby not in mothers care	
ILLNESS OF MOTHER OR INFANT Physical illness requiring that breastfeeding stop Maternal or Baby Infection (e.g. thrush, mastitis) Medication not safe in breastfeeding	
LACK OF SUPPORT Health Care Provider Hospital Staff Family/Partner	
OTHER (please specify)	

Tell me how your baby is doing (*e.g. feeding, sleeping, contentment, crying)* _____

_____

_____

_____

Any identified health problems (baby)? ☐ Yes ☐ No
If yes, please specify _____

_____

Tell me how you are doing *(e.g. sleeping, eating, mood, level of support, recovery from delivery)* _____

_____

_____

Tell me how you are feeling emotionally (If you still feel unusually sad or unhappy after 3 weeks post-baby, seek support from your health care provider) _____

_____

Any identified health problems (mom)? ☐ Yes ☐ No

If yes, please specify _____

_____

Do you have any other concerns that you would like to share?

Plans for follow-up (Resource Mother to fill out based on conversations with participant)

Attending postnatal program ☐ Yes ☐ No

Concerns identified _____

_____

_____

_____

_____

_____

_____

_____

Plans for follow up with Public Health Nurse, Nutritionist, and/or FRC Coordinator (specify) _____

_____

_____

_____

_____

_____

_____

_____

_____

Resource Mother _____ Date _____