**Assessment of maternal well-being** Day No. ☐ Where seen ☐

| Are there any concerns about the following: | No | Yes |
|---|---|---|
| **Temperature, pulse, respirations and blood pressure** Infection, fever, chills, headache, visual disturbances | ☐ | ☐ |
| **Breasts and nipples** Redness, pain, cracked, sore, bruised nipples | ☐ | ☐ |
| **Uterus** Abdominal tenderness, subinvolution | ☐ | ☐ |
| **Vaginal loss** Clots, offensive smell, return to heavy loss | ☐ | ☐ |
| **Legs** DVT, redness, swelling, pain, varicose veins, cramps | ☐ | ☐ |
| **Bladder** Pain on passing urine, leakage, urgency | ☐ | ☐ |
| **Bowels** Constipation, haemorrhoids, leakage, urgency | ☐ | ☐ |
| **Wound** Suture removal, healing, infection | ☐ | ☐ |
| **Perineum** Soreness, bruising, swelling, sutures, infection | ☐ | ☐ |
| **Pain** Headache, backache, abdominal | ☐ | ☐ |
| **Fatigue** Unable to sleep, restless sleep, extreme tiredness | ☐ | ☐ |
| **Emotions** Baby blues, excessive anxiety, postnatal depression | ☐ | ☐ |
| **Postnatal exercises** Pelvic floor, abdominal, legs, deep breathing, relaxation | ☐ | ☐ |

**Additional support required:** ☐

Specific to individual need, including referrals to social care, mental health, health visitor

**Key to risk reviewed** ☐

**Management plan reviewed / revised** ☐

Signature* 

Date/Time