**Measure 5 – Postpartum Care**

**Caregiver Measure**

**Data Collection Time Point(s)**

8 Weeks Post Birth (If enrolled prenatally) (All EBHV)

8 Weeks Post Birth (Within 8 weeks of delivery if enrolled within 30 days of giving birth) (All Non-NFP EBHV)

**Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was data for this measure collected?**

☐ Yes (Continue to 2)

☐ No (Continue to 1)

☐ Yes, with incomplete data (Continue to 2)

**1. Please provide the reason data was not collected**

☐ Caregiver exited prior to this data being collected

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Have you (Caregiver) received a postpartum visit with a health care provider?**

Yes (Continue)  No (End)

**3. If yes, date of Postpartum visit:**

\_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY