Black Infant Health

Outreach/Tracking ☐
Case Management ☐
Health Behavior Modification ☐
Social Support and Empowerment ☐

Data Forms

Name: _____ **EDC:** _____/_____/_____

Local Case #: _____ **BIH-MIS Case #:** _____

Forms	Pg	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials
Outreach Contact	1								
Client's Overview-Outreach	2								
Client Screening Instrument	3								
Client Demographics	4								
Client Medical History	5								
Client Reproductive History	6								
Client Current Pregnancy Part I	7								
Client Current Pregnancy Part II	7								
Psychosocial Factors	8								
Client Support System Information	9								
Partner Information Part I	10								
Partner Information Part II	10								
Client Referral Tracking Part I	11								
Client Referral Tracking Part II	12								
Client Referral Tracking Part III	13								

Forms	Pg	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials	Date Data Collected/ Revised Initials	Date MIS Entry Initials
Client Referral Tracking Part IV	14								
Client Referral Tracking Part V	15								
Birth Outcome-First Infant	16								
Birth Outcome-Second Infant	17								
Birth Outcome-Third Infant	18								
Well Baby Visits-First Infant	19								
Well Baby Visits-Second Infant	20								
Well Baby Visits-Third Infant	21								
Mother Follow-up to 6 Months	22								
Infant Follow-up to 6 Months	22								
Mother Follow-up to 12 Months	23								
Infant Follow-up to 12 Months	23								
Mother Follow-up to 18 Months	24								
Infant Follow-up to 18 Months	24								
Mother Follow-up to 24 Months	25								
Infant Follow-up to 24 Months	25								
Case Management Care Plan	26								
Client's Overview-Case Management	27								
Case Management Intervention/Problem Outcome	28								
~~Health Behavior Modification Care Plan~~	32								
~~Client's Overview Health Behavior Modification~~	33								
Social Support and Empowerment Care Plan	34								
Client's Overview-Social Support & Empowerment	35								
Notes	36								

Outreach Contact

Local Case #:	BIH-MIS Case #:		
Last Name	First Name	M.I.	Nickname/AKA/Maiden

Client's Mailing Address

Street Number & Name		Apartment No.
City	State	Zip Code

Home phone	Message/Work phone	DOB
( )	( )	_____/_____/_____

Outreach Worker Assigned:

Outreach Date: _____/_____/_____ **(Required)**

Source of Outreach Referral:

☐ Client (self) ☐ Canvass ☐ Agency ☐ Other

☐ Shelter
☐ Grocery Store
☐ Laundromat
☐ Street
☐ Other

☐ Health Agency
☐ Social Services
☐ Church
☐ Other

If Agency Making Referral:

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Telephone: _____

Contact Person: _____

How much convincing was needed to recruit this client? (Circle one)

1 2 3 4 5

minimum most

Do you think that your partner is interested in participating in BIH (Role of Men) ? ☐ Yes ☐ No

Comments:

Client's Overview-Outreach

BIH Entry Information

BIH Entry: _____/_____/_____ **(Required for enrolled Clients)**

Re-Entry Date: _____/_____/_____

Primary Outreach Worker:_____

BIH Closing Information

BIH Closing Date: _____/_____/_____

Reason:

1. ☐ Service Completed
2. ☐ Client Voluntarily Exited
3. ☐ No Longer Eligible
4. ☐ Moved-No Transfer To Another BIH H.J.
5. ☐ Moved-Transfer To Another BIH H.J.
6. ☐ Unable To Locate/Unresponsive
7. ☐ Death-Index Child
8. ☐ Death-Client
9. ☐ Other

Things To Do

	Date
1. _____	_____/_____/_____
2. _____	_____/_____/_____
3. _____	_____/_____/_____
4. _____	_____/_____/_____
5. _____	_____/_____/_____
6. _____	_____/_____/_____
7. _____	_____/_____/_____
8. _____	_____/_____/_____
9. _____	_____/_____/_____

Positive Reinforcement Words & Statements

_____

_____

_____

_____

Date: _____/_____/_____

CLIENT SCREENING INSTRUMENT

Screener's Name:_____ Job Title:_____

☐ Interview ☐ Self-Report Time it took to complete_____

1. Are you under 18 years of age? ☐ Yes-1 ☐ No-0 _____

2. Do you ever worry about making ends meet? ☐ Yes-1 ☐ No-0 _____

3. Do you feel comfortable with your living arrangements? ☐ Yes-0 ☐ No-1 _____

4. Do you see a doctor/nurse or go to a clinic for your pregnancy? ☐ Yes-0 ☐ No-1 _____

5. Do you feel respected by the doctor/nurse, or other staff? ☐ Yes-0 ☐ No-1 _____

6. If you could, would you go to a different doctor/clinic? ☐ Yes ☐ No
   - If yes and reason is “racism/discrimination” ☐ Yes-1 ☐ No-0 _____
   - If yes and reason is another reason ☐ Yes-0 ☐ No-0 _____

7. How important is it to keep your prenatal health care appointments?
   - Very Important ☐ Yes-0 _____
   - Important ☐ Yes-1 _____
   - Not Important ☐ Yes-1 _____

8. If you were to miss a prenatal healthcare appointment, what would probably be the reason?
   - If reason is close to "no money/no insurance" ☐ Yes-1 _____
   - If any other reason ☐ Yes-0 _____

9. Please list the first names (or initials) of people you feel close to:

Name/Initials	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

1. Mother
2. FOB
3. Other Relative
4. Not Relative

   - If fewer than 3 people ☐ Yes-1 _____
   - If 3 or more people ☐ Yes-0 _____

   - If all people listed above related to client ☐ Yes-1 _____
   - If any people listed above not related to client ☐ Yes-0 _____
   - If mother <u>not</u> on list ☐ Yes-1 _____

10. Are you or have you been involved with gangs? ☐ Yes-1 ☐ No-0 _____

CLIENT SCREENING INSTRUMENT

11. Did any of the following happen to you in the last 12 months?

You moved	☐ Yes-1	☐ No-0	_____
A close friend died	☐ Yes-1	☐ No-0	_____
Your income decreased	☐ Yes-1	☐ No-0	_____
Your partner physically hurt you	☐ Yes-1	☐ No-0	_____
You got into debt over your head	☐ Yes-1	☐ No-0	_____
You were involved in a physical fight	☐ Yes-1	☐ No-0	_____
Someone very close to you had a bad problem with drinking or drugs	☐ Yes-1	☐ No-0	_____

12. Did you feel any of the following in the past month?

Woke up fresh and rested	☐ Yes-0	☐ No-1	_____
Had trouble paying attention	☐ Yes-1	☐ No-0	_____
So restless that you couldn't sit long in a chair	☐ Yes-1	☐ No-0	_____
Criticized a lot by others	☐ Yes-1	☐ No-0	_____
Very lonely or isolated from other people	☐ Yes-1	☐ No-0	_____
Bored	☐ Yes-1	☐ No-0	_____

13. Do you feel that your partner will be there for you once the baby is born?	☐ Yes-0	☐ No-1	_____
14. Does your partner provide you with financial support?	☐ Yes-0	☐ No-1	_____
15. Can you depend on your partner for financial support?	☐ Yes-0	☐ No-1	_____
16. Is your partner now or has he ever been in jail?	☐ Yes-1	☐ No-0	_____
17. Does your partner emotionally support this pregnancy?	☐ Yes-0	☐ No-1	_____
18. Do you drink liquor?	☐ Yes-1	☐ No-0	_____
19. Were you ever in a special class or in "special ed."?	☐ Yes-1	☐ No-0	_____
20. **If** you had a previous birth, was the baby born healthy? (If no previous birth, leave blank)	☐ Yes-0	☐ No-1	_____
		Total Score:	_____

SERVICE DECISION (to be made after completing the Client Screening Instrument) (Required):

Staff Screening Instrument Score _____ _____ _____ _____ _____ _____

☐ Enroll in BIH program

_____ Outreach/Tracking _____ Case Management

_____ Health Behavior Modification _____ Social Support & Empowerment

☐ Refer out (Not Enrolled in BIH)_____

Exception to cut-off point: Enrollment based on the existence of the following problem

_____

Client's Demographics

Local Case #: BIH-MIS Case #:

Last Name	First Name	M.I.	Nickname/AKA/Maiden

Client's Mailing Address

Street Number & Name	Apartment No.	City	State	Zip Code

Client's Home Address (if different from mailing address)

Street Number & Name	Apartment No.	City	State	Zip Code

Home phone	Message/Work phone	P. O. Box :		
( )	( )	DOB	Age	SSN
( )	( )			

Monthly Gross Income: $_____

a. Primary Income Source.
1. ☐ Employment
2. ☐ Self-employment
3. ☐ Unemployment Ins.
4. ☐ Partner
5. ☐ Parents
6. ☐ AFDC
7. ☐ SSI/Disability
8. ☐ County/Court Support
9. ☐ Disability
10. ☐ General Relief
11. ☐ Other
12. ☐ Unknown
13. ☐ None
14. ☐ Declined to Respond

b.Employment Status
1. ☐ Not employed
2. ☐ Part-time
3. ☐ Full-time
4. ☐ Seasonal
5. ☐ Unknown
6. ☐ Volunteer

c. Education Status
1. ☐ None
2. ☐ Elementary School (1-6)
3. ☐ Middle/Jr High School (7-9)
4. ☐ High School (10-12)-Didn't graduate
5. ☐ High School Graduate/GED
6. ☐ Attended College-No degree
7. ☐ Associate Degree
8. ☐ Bachelor's Degree
9. ☐ Master's Degree
10. ☐ Vocational School
11. ☐ Unknown

d. School Attendance
1. ☐ Not Attending
2. ☐ Full-time High Sch.
3. ☐ Part-time High Sch.
4. ☐ Full-time College
5. ☐ Part-time College
6. ☐ Vocational
7. ☐ Other
8. ☐ Unknown

e. Housing Needs
1. ☐ Not Required
2. ☐ Required Urgently
3. ☐ Required within 2 Weeks
4. ☐ Required within 30 Days
5. ☐ Required within 60 Days
6. ☐ Required within 120 Days
7. ☐ Unknown

f. Transportation Need
1. ☐ Not Required
2. ☐ Required Occasionally
3. ☐ Required Full-time
4. ☐ Unknown

g. Marital Status
1. ☐ Married to Father of the Baby
2. ☐ Married to Other Than FOB
3. ☐ Single
4. ☐ Divorced
5. ☐ Separated
6. ☐ Widowed
7. ☐ Unknown

h. Judicial Problem
1. ☐ None
2. ☐ Pending
3. ☐ Incarcerated
4. ☐ Probation
5. ☐ Parole
6. ☐ Unknown

i. Child Care Needs
1. ☐ Not Required
2. ☐ Required Urgently
3. ☐ Required in 2 Weeks
4. ☐ Required in 30 Days
5. ☐ Required in 60 Days
6. ☐ Required in 120 Days
7. ☐ Unknown

j. English Proficiency
1. ☐ English only
2. ☐ Fully English Proficient
3. ☐ Limited English Proficient
4. ☐ Non-English Speaking
5. ☐ Status Unknown
6. ☐ Redesignated Fluent English Proficiency

k. Preferred Language
1. ☐ English
2. ☐ Spanish
3. ☐ French
4. ☐ Other

Children (List Youngest)

Sex Age Name

1. _____ Total # of Children: _____
2. _____ Total # of Children Living with Client: _____
3. _____

Client's Medical History

Previous Conditions (Most Recent)

☐ None ☐ Unknown

Date:		Date:	
_____/_____/_____	☐ Anemia	_____/_____/_____	☐ Psychological Problems
_____/_____/_____	☐ Asthma	_____/_____/_____	☐ Pyelonephritis
_____/_____/_____	☐ Chlamydia	_____/_____/_____	☐ Rh Negative
_____/_____/_____	☐ High Cholesterol	_____/_____/_____	☐ Seizures
_____/_____/_____	☐ Diabetes-Chronic	_____/_____/_____	☐ Sickle Cell
_____/_____/_____	☐ Fibroids	_____/_____/_____	☐ Substance Abuse
_____/_____/_____	☐ Gonorrhea	_____/_____/_____	☐ Syphillis
_____/_____/_____	☐ Heart Disease	_____/_____/_____	☐ Transfusions
_____/_____/_____	☐ Hepatitis B	_____/_____/_____	☐ Trichomonas
_____/_____/_____	☐ Herpes	_____/_____/_____	☐ Tuberculosis
_____/_____/_____	☐ Hypertension	_____/_____/_____	☐ Ulcer
_____/_____/_____	☐ Mitral Valve Prolapse	_____/_____/_____	☐ Urinary Tract Infection
_____/_____/_____	☐ Pneumonia	_____/_____/_____	☐ Venereal Warts
		_____/_____/_____	☐ Other_____

Previous Health Services

If Problem, explain:

	Date of most recent:
Pap smear	_____/_____/_____
Gynecological Examination	_____/_____/_____
Physical Examination	_____/_____/_____
HIV Test	_____/_____/_____
Dental Examination	_____/_____/_____

Client's Reproductive History

Previous Pregnancy (Required) (Do not include current pregnancy)

# of Previous Pregnancies _____ # of Births _____

# of Spontaneous Abortions _____ # Terminated _____

(# of births + # of SABs + # of terminated should equal # of pregnancies, except for multiple births)

Previous Pregnancy Problems (Most Recent)

☐ None ☐ Unknown

Date:

_____/_____/_____ ☐ Abruptio Placenta

_____/_____/_____ ☐ Anemia

_____/_____/_____ ☐ Babies < 5 lbs 8 oz

_____/_____/_____ ☐ Babies > 9 lbs

_____/_____/_____ ☐ Breech

_____/_____/_____ ☐ Cesarean Sections

_____/_____/_____ ☐ Birth Defects

_____/_____/_____ ☐ Ectopic Pregnancy

_____/_____/_____ ☐ Gestational Diabetes

_____/_____/_____ ☐ Intrauterine Fetal Demise

_____/_____/_____ ☐ Neonatal Death

_____/_____/_____ ☐ Placenta Previa

_____/_____/_____ ☐ Post Neonatal Death

_____/_____/_____ ☐ Postpartum Hemorrhage

_____/_____/_____ ☐ Pregnancy Induced Hypertension

_____/_____/_____ ☐ Preterm Delivery

_____/_____/_____ ☐ Preterm Labor

_____/_____/_____ ☐ Pyelonephritis

_____/_____/_____ ☐ Urinary Tract Infection

_____/_____/_____ ☐ Other _____

Birth Control Methods Prior to This Pregnancy

☐ Condoms w/Spermicide

☐ Condoms w/o Spermicide

☐ Daily Birth Control Pills

☐ Diaphragm/Cervical Cap

☐ Emergency Contraception

☐ Implants (i.e. Norplant)

☐ Injections (i.e. Depo-Provera)

☐ IUC-Intrauterine Contraceptive

☐ Lactational Amenorrhea Method

☐ Patch

☐ Ring

☐ Rhythm/Natural

☐ Sponge/Foam

☐ Tubal Ligation

☐ Vasectomy

☐ Withdrawal

☐ Other: _____

☐ None

☐ Unknown

☐ Declined to Respond

Previous Complications:

Client's Current Pregnancy-Part 1

Pregnancy Information
MM/DD/YY

LMP_____/_____/_____

EDC_____/_____/_____

PNC Provider Name:

_____

PNC Visits Dates:
MM/DD/YY

____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____
____/____/____ ____/____/____

Primary Payment Source

1. ☐ Medicare
2. ☐ Medi-Cal
3. ☐ Worker's Compensation
4. ☐ Title V
5. ☐ Other Government
6. ☐ Blue Cross/Blue Shield
7. ☐ Insurance Company
8. ☐ HMO/PHP
9. ☐ Self-Pay
10. ☐ No Charge
11. ☐ Other Non-Government
12. ☐ Medically Indigent
13. ☐ Unknown

Current Pregnancy Problems

MM/DD/YY

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

☐ Anemia
☐ Gestational Diabetes
☐ Placenta Previa
☐ Pregnancy Induced Hypertension
☐ Premature Labor
☐ Pyelonephritis
☐ Rh Negative
☐ Urinary Tract Infection
☐ Other _____
☐ None
☐ Unknown

Health Plan Name

_____

CPSP Client ☐

Chronic Illness: _____
Mental Illness: _____
Allergies: _____
Med. Allergies: _____

Medication	Duration	Dose	Reason

Planned Pregnancy? ☐ No ☐ Yes ☐ Declined to Respond

Prepregnancy Weight (lbs): _____

Client's Height: _____ft _____ in

Body Mass Index **(MIS Calculation)**: _____

Weight Gain 1st Trimester (lbs): _____

Weight Gain 2nd Trimester (lbs): _____

Weight Gain 3rd Trimester (lbs): _____

Notes/Complications:

Client's Current Pregnancy-Part 2

Cigarette Use During Pregnancy

1. ☐ Never/None
2. ☐ Stopped Before Conception
3. ☐ Quit First Trimester
4. ☐ Quit Second Trimester
5. ☐ Quit Third Trimester
6. ☐ Smokes or Resumed During Pregnancy
7. ☐ Use Denied-But Suspected
8. ☐ Declined to Respond
9. ☐ Unknown

How Much

1. ☐ Less Than 1/2 Pack/Day
2. ☐ Less Than 1 Pack /Day
3. ☐ One Pack/Day
4. ☐ More Than One Pack/Day
5. ☐ Unknown

Daily Exposure to Second Hand Smoke

☐ Yes-At Work
☐ Yes-At Home

Alcohol Use During Pregnancy

1. ☐ Never/None
2. ☐ Stopped Before Conception
3. ☐ Quit First Trimester
4. ☐ Quit Second Trimester
5. ☐ Quit Third Trimester
6. ☐ Drinks or Resumed During Pregnancy
7. ☐ Use Denied-But Suspected
8. ☐ Declined to Respond
9. ☐ Unknown

How Much

1. ☐ One Drink
2. ☐ Two Drink
3. ☐ Three Drinks
4. ☐ Four Drinks
5. ☐ Intoxication
6. ☐ Occasional Intoxication
7. ☐ Binge/Episodic
8. ☐ Denied but Suspected
9. ☐ Declined to Respond

Frequency

1. ☐ Everyday
2. ☐ Twice a Week
3. ☐ Weekends
4. ☐ Once a Month
5. ☐ Occasionally
6. ☐ Unknown

☐ Rehab Date: _____/_____/_____

Completed ☐ Site/Agency:_____

Illicit Drug Use ☐ Never used ☐ No current use

First Drug:

1. ☐ Cocaine/ Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

____ Times per

Day Week Month

Second Drug:

1. ☐ Cocaine/ Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

____ Times per

Day Week Month

Third Drug:

1. ☐ Cocaine/ Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

____ Times per

Day Week Month

Rehab ☐ Date: _____/_____/_____ Completed ☐ Site/Agency: _____

Psychosocial Factors

Client's Concerns/Challenges Re:

- ☐ None
- ☐ Unprepared for Baby
- ☐ Unprepared for Birth
- ☐ Birthing
- ☐ Child Abuse
- ☐ Child Care
- ☐ Cultural Beliefs
- ☐ Debt/Finances
- ☐ Depression
- ☐ Employment
- ☐ Environment
- ☐ Family Disapproval
- ☐ Housing
- ☐ Judicial
- ☐ Living Situation
- ☐ Neighborhood
- ☐ Nutrition
- ☐ Partner Abuse
- ☐ Partner Preparedness
- ☐ Pregnancy
- ☐ Psychiatric
- ☐ Sexual Abuse
- ☐ Social Support
- ☐ Substance Abuse
- ☐ Transportation
- ☐ Violence-Family
- ☐ Violence-Community

Social Support From:

- ☐ None
- ☐ Baby's Father
- ☐ Client's Mother
- ☐ Client's Father
- ☐ Grandparents
- ☐ Sister
- ☐ Brother
- ☐ Other Relative
- ☐ Friend
- ☐ Church Member
- ☐ Community Member
- ☐ Community Agency
- ☐ Psychiatrist
- ☐ Subst. Abuse Counselor
- ☐ Other

Client's Reaction to Preg.

1. ☐ Wants Child
2. ☐ Does Not Want Child
3. ☐ Ambivalent
4. ☐ Other
5. ☐ Unknown

Father's Reaction to Preg.

1. ☐ Wants Child
2. ☐ Does Not Want Child
3. ☐ Ambivalent
4. ☐ Denies Paternity
5. ☐ Other
6. ☐ Unknown

Client's Residence Type

1. ☐ Client's Home (own or rent)
2. ☐ Parents' or Guardians' Home
3. ☐ Other Adults' Home
4. ☐ Foster Home
5. ☐ Boarding House
6. ☐ Cooperative House
7. ☐ Dormitory
8. ☐ Rooming House
9. ☐ Shelter/Crisis
10. ☐ Shelter/Disaster
11. ☐ Shelter/Transient
12. ☐ Licensed Children's Center
13. ☐ Residential Treatment Center
14. ☐ Youth Detention Center
15. ☐ No Home
16. ☐ Other
17. ☐ Unknown

Family/Living Situation

1. ☐ Living with Father of Baby
2. ☐ Living with Other Than Father of Baby
3. ☐ Living with Family
4. ☐ Living with Friend(s)
5. ☐ Living Alone
6. ☐ Unknown

Household Size: _____

Client's Support System Information

For FOB or Partner, see Partner Information Form

Name	Address	Area	Telephone
Client's Mother			
Client's Father			
Client's Grandparent(s)			
Client's Relative(s)			
Client's Friend(s)			
Church/Religious Organization			
Community Member(s)			
Community Agency			
Social Worker			
Substance Abuse Counselor			
Abuse Counselor			
Other			

Partner Information-Part 1

10-1

Last Name	First Name	M.I.	Nickname/AKA

Street Address	Apt #	City	State	Zip

Home phone	Message/work phone	DOB	SSN	Father of Baby:
				Yes __ No __

a. Primary Income Source
1. ☐ Employment
2. ☐ Self-employment
3. ☐ Unemployment Ins.
4. ☐ Partner
5. ☐ Parents
6. ☐ AFDC
7. ☐ SSI/Disability
8. ☐ County/Court support
9. ☐ Disability
10. ☐ General relief
11. ☐ Other
12. ☐ Unknown
13. ☐ None

b. Financial Support to
1. ☐ Mother
2. ☐ Child
3. ☐ Both
4. ☐ Unknown
5. ☐ None

c. Employment Status
1. ☐ Not employed
2. ☐ Part Time
3. ☐ Full Time
4. ☐ Seasonal
5. ☐ Unknown
6. ☐ Volunteer

d. Type of Work
1. ☐ Construction
2. ☐ Technical
3. ☐ Professional
4. ☐ Unskilled
5. ☐ Laborer
6. ☐ Unknown

e. Education Status
1. ☐ None
2. ☐ Elementary School (1-6)
3. ☐ Middle/Jr High School (7-9)
4. ☐ High School (10-12)- Did not graduate
5. ☐ High School Graduate/GED
6. ☐ Attended College-No degree
7. ☐ Associate Degree
8. ☐ Bachelor's Degree
9. ☐ Master's Degree
10. ☐ Vocational School
11. ☐ Unknown

f. School Attendance.
1. ☐ Not Attending
2. ☐ Full Time-HS
3. ☐ Part Time-HS
4. ☐ Full Time-College
5. ☐ Part Time-College
6. ☐ Vocational
7. ☐ Other
8. ☐ Unknown

g. General Health
1. ☐ Excellent
2. ☐ Good
3. ☐ Fair
4. ☐ Poor
5. ☐ Unknown

h. Judicial Problems
1. ☐ None
2. ☐ Pending
3. ☐ Incarcerated
4. ☐ Probation
5. ☐ Parole
6. ☐ Unknown

i. Marital Status
1. ☐ Married to Client
2. ☐ Married to Other than Client
3. ☐ Single
4. ☐ Divorced
5. ☐ Separated
6. ☐ Widowed
7. ☐ Unknown

j. Reaction To Pregnancy
1. ☐ Wants Child
2. ☐ Does not Want Child
3. ☐ Ambivalent
4. ☐ Denies paternity
5. ☐ Other
6. ☐ Unknown

k. Infant Contact
1. ☐ Daily
2. ☐ 2 to 6 per week
3. ☐ 1 per week
4. ☐ 2 to 3 per month
5. ☐ 1 per month
6. ☐ None
7. ☐ Other
8. ☐ Unknown

l. Parenting/Skills
1. ☐ Active Care Giving
2. ☐ Occasional Care Giving
3. ☐ Visits-Without Care Giving
4. ☐ No Contact
5. ☐ Unknown

m. English Proficiency
1. ☐ English only
2. ☐ Fully English Proficient
3. ☐ Limited English Proficient
4. ☐ Non-English Speaking
5. ☐ Status Unknown
6. ☐ Redesignated Fluent English Proficient

n. Preferred Language
1. ☐ English
2. ☐ Spanish
3. ☐ French
4. ☐ Chinese
5. ☐ Arabic
6. ☐ Vietnamese
7. ☐ Other

Vocational Training Site:

Children (List Youngest)

	Sex	Age	Name
1.			
2.			
3.			

Total # of Children: _____

Total # of Children Living with Partner: _____

Partner Information - Part 2

10-2

Cigarette Use During Pregnancy

1. ☐ Never/None
2. ☐ Stopped Before Conception
3. ☐ Quit First Trimester
4. ☐ Quit Second Trimester
5. ☐ Quit Third Trimester
6. ☐ Smokes or Resumed During Pregnancy
7. ☐ Use Denied-But Suspected
8. ☐ Declined to Respond
9. ☐ Unknown

How Much

1. ☐ Less Than 1/2 Pack/Day
2. ☐ Less Than 1 Pack /Day
3. ☐ One Pack/Day
4. ☐ More Than One Pack/Day
5. ☐ Unknown

Daily Exposure to Second Hand Smoke

☐ Yes-At Work
☐ Yes-At Home

Alcohol Use

1. ☐ Never/None
2. ☐ One Drink
3. ☐ Two Drink
4. ☐ Three Drinks
5. ☐ Four Drinks
6. ☐ Intoxication
7. ☐ Occasional Intoxication
8. ☐ Binge/Episodic
9. ☐ Denied but Suspected
10. ☐ Declined to Respond
11. ☐ Unknown

Frequency

1. ☐ Everyday
2. ☐ Twice a Week
3. ☐ Weekends
4. ☐ Once a Month
5. ☐ Occasionally
6. ☐ Unknown

☐ Rehab Date: _____/_____/_____

Completed ☐ Site/Agency:_____

Illicit Drug Use

☐ Never used ☐ No current use

First Drug:

1. ☐ Cocaine/Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

_____ Times per

Day Week Month

Second Drug:

1. ☐ Cocaine/Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

_____ Times per

Day Week Month

Third Drug:

1. ☐ Cocaine/Crack Cocaine
2. ☐ Marijuana
3. ☐ Methamphetamine
4. ☐ Hallucinogens (PCP, LSD, Mescaline)
5. ☐ Tranquilizers (Valium, Thorazine)
6. ☐ Inhalants (Glue Sniffing)
7. ☐ Methadone
8. ☐ Barbiturates
9. ☐ Heroin/Opiates (Morphine, Codeine, Opium)
10. ☐ Other
11. ☐ Use Denied-But Suspected
12. ☐ Declined to Respond
13. ☐ Unknown

_____ Times per

Day Week Month

Rehab ☐ Date: _____/_____/_____ Completed ☐ Site/Agency: _____

Client Referral Tracking - Part 1

Dates Referred	Number of Times Referred	Referral Provider/ Agency	Client Barriers (See legend)	Follow-Up Date	Final Referral Results (See legend)
Pregnancy Services					
1. Adolescent					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Childbirth Education					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Genetic Services					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. High Risk Pregnancy					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
5. Prenatal Care					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
6. WIC (Prenatal)					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
7. Substance Abuse					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
8. Public Health Nurse					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____

Barriers to Keeping Referral

1. Child Care
2. Transportation
3. Forgot Appointment
4. Unavailable Appointment
5. Unable to Locate Agency
6. Lack of Support from Partner
7. Lack of Money/Insurance for Care
8. Negative Experience with Previous Treatment
9. Unknown
10. Other : _____

Final Referral Results

1. Received Service
2. Referred, But Did Not Go
3. Referral Not Accessible
4. Referral Not Available
5. Referral Refused
6. Not Eligible for Service
7. Referred, Unknown Outcome
8. Unknown

Client Referral Tracking - Part 2

Dates Referred	Number of Times Referred	Referral Provider/Agency	Client Barriers (See legend)	Follow-Up Date	Final Referral Results (See legend)
Family/Support Services					
1. WIC (Children)					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Medi-Cal Assistance					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Public Assistance					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. Disability-Client/Family Member					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
5. Child Abuse/Neglect					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
6. Child Care					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
7. Transportation					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
8. Food/Nutrition Services					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
9. Housing/Shelter					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
10. Legal Assistance					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
11. Medical Equipment/Appliances					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
12. Probation/Justice System					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____

Barriers to Keeping Referral

1. Child Care
2. Transportation
3. Forgot Appointment
4. Unavailable Appointment
5. Unable to Locate Agency
6. Lack of Support from Partner
7. Lack of Money/Insurance for Care
8. Negative Experience with Previous Treatment
9. Unknown
10. Other : _____

Final Referral Results

1. Received Service
2. Referred, But Did Not Go
3. Referral Not Accessible
4. Referral Not Available
5. Referral Refused
6. Not Eligible for Service
7. Referred, Unknown Outcome
8. Unknown

Client Referral Tracking - Part 3

Dates Referred	Number of Times Referred	Referral Provider/Agency	Client Barriers (See legend)	Follow-Up Date	Final Referral Results (See legend)
Postpartum Services					
1. Breastfeeding					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Home Care					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Parenting Support					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. Family Planning					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
Newborn Care					
1. Adoption					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Infant Care					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Child Growth and Development					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. Special Needs Newborn/Infant					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
5. Immunizations					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____

Barriers to Keeping Referral

1. Child Care
2. Transportation
3. Forgot Appointment
4. Unavailable Appointment
5. Unable to Locate Agency
6. Lack of Support from Partner
7. Lack of Money/Insurance for Care
8. Negative Experience with Previous Treatment
9. Unknown
10. Other : _____

Final Referral Results

1. Received Service
2. Referred, But Did Not Go
3. Referral Not Accessible
4. Referral Not Available
5. Referral Refused
6. Not Eligible for Service
7. Referred, Unknown Outcome
8. Unknown

Client Referral Tracking - Part 4

Dates Referred	Number of Times Referred	Referral Provider/Agency	Client Barriers (See legend)	Follow-Up Date	Final Referral Results (See legend)
Counseling & Education					
1. Family Violence					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Grief Counseling					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Postpartum Depression					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. Substance Abuse					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
5. Parenting Education					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
6. GED					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
7. Adult Education					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
8. Vocational & Jobs					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____

Barriers to Keeping Referral

1. Child Care
2. Transportation
3. Forgot Appointment
4. Unavailable Appointment
5. Unable to Locate Agency
6. Lack of Support from Partner
7. Lack of Money/Insurance for Care
8. Negative Experience with Previous Treatment
9. Unknown
10. Other : _____

Final Referral Results

1. Received Service
2. Referred, But Did Not Go
3. Referral Not Accessible
4. Referral Not Available
5. Referral Refused
6. Not Eligible for Service
7. Referred, Unknown Outcome
8. Unknown

Client Referral Tracking - Part 5

Dates Referred	Number of Times Referred	Referral Provider/Agency	Client Barriers (See legend)	Follow-Up Date	Final Referral Results (See legend)
Case Management					
1. Pregnancy					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
2. Postpartum					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
3. Newborn Care					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
4. Finding a Doctor					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
Other Services					
_____					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
_____					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____
_____					
___/___/___ ___/___/___ ___/___/___	_____	_____	_____	___/___/___	_____

Barriers to Keeping Referral

1. Child Care
2. Transportation
3. Forgot Appointment
4. Unavailable Appointment
5. Unable to Locate Agency
6. Lack of Support from Partner
7. Lack of Money/Insurance for Care
8. Negative Experience with Previous Treatment
9. Unknown
10. Other : _____

Final Referral Results

1. Received Service
2. Referred, But Did Not Go
3. Referral Not Accessible
4. Referral Not Available
5. Referral Refused
6. Not Eligible for Service
7. Referred, Unknown Outcome
8. Unknown

Birth Outcome-First Infant

Pregnancy Outcome Date:_____/_____/_____ **(Required)**

Gestation Weeks: _____ Delivery Site: _____

Days Client in Hospital: _____ Reason: _____

Re-hospitalization of Client Related to Birth-Days: _____ Reason: _____

Delivery Attendant

1. ☐ Physician/Medical Doctor
2. ☐ Doctor Osteopathic/Chiropractor
3. ☐ Certified Nurse/Midwife
4. ☐ Registered Nurse/Physician Assistant
5. ☐ Other Midwife
6. ☐ Other
7. ☐ Unattended
8. ☐ Unknown

Type of Delivery

1. ☐ Vaginal
2. ☐ Vaginal Birth After C-Section
3. ☐ C-Section-Primary
4. ☐ C-Section-Repeat
5. ☐ Unknown

Pregnancy Outcome

1. ☐ Live Birth
2. ☐ Neonatal Death
3. ☐ Fetal Death
4. ☐ Spontaneous Abortion
5. ☐ Therapeutic Abortion
6. ☐ Post Neonatal Death

Delivery Complications

1. ☐ Preterm Delivery
2. ☐ Breech
3. ☐ Intrauterine Fetal Demise
4. ☐ Other_____

Client's Child Care Skills

1. ☐ Skilled
2. ☐ Lacks Skill
3. ☐ Unknown

Client's Child Care Interest

1. ☐ Interested in Caring For Baby
2. ☐ Not Interested in Caring For Baby
3. ☐ Unknown

Client's Reaction To Birth

1. ☐ Wants Child
2. ☐ Does not Want Child
3. ☐ Ambivalent
4. ☐ Other
5. ☐ Unknown

Infant Information

Infant Name: _____ ☐ **Female** ☐ **Male**

Birth Weight (lbs-oz/grams) _____

Length (in./cm) _____

APGAR Score (5 min) _____

Birth Defects

1. ☐ None
2. ☐ Minor
3. ☐ Major
4. ☐ Unknown

Birth Defect Details: _____

_____

Days Infant in Hospital _____ Reason: _____

Days Infant in Neonatal ICU _____ Reason: _____

Infant Discharged to:

1. ☐ Natural Parents
2. ☐ Mother Only
3. ☐ Father Only
4. ☐ Foster Care
5. ☐ Grandparents
6. ☐ Other Family Member
7. ☐ Adoption
8. ☐ Unknown
9. ☐ CPS

Pediatric Care Provider:

1. ☐ Physician/Medical Doctor
2. ☐ Registered Nurse/Physician Assistant
3. ☐ Other
4. ☐ Unknown/Unattended

Pediatric Care Provider Name: _____ **Phone Number:** ( ) ----

Breastfeeding

Breastfeeding Initiation: 1. ☐ Yes 2. ☐ No If **NO**, what was/were the reasons?

1. ☐ Don't Know How to Breastfeed
2. ☐ Job/Scheduling Difficulties
3. ☐ Mother's Physical/Medical Difficulties
4. ☐ Infant's Physical/Medical Difficulties
5. ☐ Preferred Bottle Feeding
6. ☐ Other: _____
7. ☐ Declined to Respond

Concerns at Birth: _____

Birth Outcome-Second Infant (Twin)

Pregnancy Outcome Date:_____/_____/_____ **(Required)**

Gestation Weeks: _____ Delivery Site: _____

Days Client in Hospital: _____ Reason: _____

Re-hospitalization of Client Related to Birth-Days: _____ Reason: _____

Delivery Attendant

1. ☐ Physician/Medical Doctor
2. ☐ Doctor Osteopathic/Chiropractor
3. ☐ Certified Nurse/Midwife
4. ☐ Registered Nurse/Physician Assistant
5. ☐ Other Midwife
6. ☐ Other
7. ☐ Unattended
8. ☐ Unknown

Type of Delivery

1. ☐ Vaginal
2. ☐ Vaginal Birth After C-Section
3. ☐ C-Section-Primary
4. ☐ C-Section-Repeat
5. ☐ Unknown

Pregnancy Outcome

1. ☐ Live Birth
2. ☐ Neonatal Death
3. ☐ Fetal Death
4. ☐ Spontaneous Abortion
5. ☐ Therapeutic Abortion
6. ☐ Post Neonatal Death

Delivery Complications

1. ☐ Preterm Delivery
2. ☐ Breech
3. ☐ Intrauterine Fetal Demise
4. ☐ Other_____

Infant Information

Infant Name: _____ ☐ **Female** ☐ **Male**

Birth Weight (lbs-oz/grams) _____

Length (in./cm) _____

APGAR Score (5 min) _____

Days Infant in Hospital _____ Reason: _____

Days Infant in Neonatal ICU _____ Reason: _____

Birth Defects

1. ☐ None
2. ☐ Minor
3. ☐ Major
4. ☐ Unknown

Birth Defect Details: _____

_____

Infant Discharged to:

1. ☐ Natural Parents
2. ☐ Mother Only
3. ☐ Father Only
4. ☐ Foster Care
5. ☐ Grandparents
6. ☐ Other Family Member
7. ☐ Adoption
8. ☐ Unknown
9. ☐ CPS

Concerns at Birth: _____

Birth Outcome-Third Infant (Triplet)

Pregnancy Outcome Date:_____/_____/_____ **(Required)**

Gestation Weeks: _____ Delivery Site: _____

Days Client in Hospital: _____ Reason: _____

Re-hospitalization of Client Related to Birth-Days: _____ Reason: _____

Delivery Attendant

1. ☐ Physician/Medical Doctor
2. ☐ Doctor Osteopathic/Chiropractor
3. ☐ Certified Nurse/Midwife
4. ☐ Registered Nurse/Physician Assistant
5. ☐ Other Midwife
6. ☐ Other
7. ☐ Unattended
8. ☐ Unknown

Type of Delivery

1. ☐ Vaginal
2. ☐ Vaginal Birth After C-Section
3. ☐ C-Section-Primary
4. ☐ C-Section-Repeat
5. ☐ Unknown

Pregnancy Outcome

1. ☐ Live Birth
2. ☐ Neonatal Death
3. ☐ Fetal Death
4. ☐ Spontaneous Abortion
5. ☐ Therapeutic Abortion
6. ☐ Post Neonatal Death

Delivery Complications

1. ☐ Preterm Delivery
2. ☐ Breech
3. ☐ Intrauterine Fetal Demise
4. ☐ Other_____

Infant Information

Infant Name: _____ ☐ **Female** ☐ **Male**

Birth Weight (lbs-oz/grams) _____

Length (in./cm) _____

APGAR Score (5 min) _____

Days Infant in Hospital _____ Reason: _____

Days Infant in Neonatal ICU _____ Reason: _____

Birth Defects

1. ☐ None
2. ☐ Minor
3. ☐ Major
4. ☐ Unknown

Birth Defect Details: _____

_____

Infant Discharged to:

1. ☐ Natural Parents
2. ☐ Mother Only
3. ☐ Father Only
4. ☐ Foster Care
5. ☐ Grandparents
6. ☐ Other Family Member
7. ☐ Adoption
8. ☐ Unknown
9. ☐ CPS

Concerns at Birth: _____

Well Baby Visits-First Infant

Date MM/DD/YY	Weight (lbs/oz)	Age (months)	Currently Breastfeeding	Provider/Clinic for WBV	Father Attended
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes

Comments: _____

_____

_____

Immunizations

6 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

18 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

12 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

24 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

Comments: _____

_____

_____

Well Baby Visits-Second Infant (Twin)

Date MM/DD/YY	Weight (lbs/oz)	Age (months)	Currently Breastfeeding	Provider/Clinic for WBV	Father Attended
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes

Comments: _____

_____

_____

Immunizations

6 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

18 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

12 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

24 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

Comments: _____

_____

_____

Well Baby Visits-Third Infant (Triplet)

Date MM/DD/YY	Weight (lbs/oz)	Age (months)	Currently Breastfeeding	Provider/Clinic for WBV	Father Attended
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes
____/____/____	_____	_____	☐ Yes	_____	☐ Yes

Comments: _____

_____

_____

Immunizations

6 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

18 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

12 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

24 Months

- ☐ Up-to-Date
- ☐ Not Up-to-Date
- ☐ Not Assessed
- ☐ Client Chooses Not to Immunize Infant

Comments: _____

_____

_____

Date: ___/___/___ (Required) **Mother Follow-up to 6 Months Postpartum** **22-1**

Birth Control Method Use:
1. ☐ Never
2. ☐ Sometimes
3. ☐ Always
4. ☐ No Sexual Activity During This Period- No Partner
5. ☐ No Sexual Activity During This Period- Abstaining
6. ☐ Client Pregnant During Entire Period
7. ☐ Unknown
8. ☐ Declined to Respond

Birth control method use from birth to 6 months postpartum (mark all that apply)
1. ☐ Condoms w/Spermicide
2. ☐ Condoms w/o Spermicide
3. ☐ Daily Birth Control Pills
4. ☐ Diaphragm/Cervical Cap
5. ☐ Emergency Contraceptive
6. ☐ Implants (i.e. Norplant)
7. ☐ Injections (i.e. Depo-Provera)
8. ☐ IUC-Intrauterine Contraception
9. ☐ Lactational Amenorrhea Method
10. ☐ Patch
11. ☐ Ring
12. ☐ Rhythm/Natural
13. ☐ Sponge/Foam
14. ☐ Tubal Ligation
15. ☐ Vasectomy
16. ☐ Withdrawal
17. ☐ Other: _____
18. ☐ Unknown
19. ☐ Declined to Respond

Has client received treatment for a chronic health problem from delivery to 6 months postpartum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client received treatment for an acute health problem since delivery to 6 months post partum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems, but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client reported any physical abuse (being hit, slapped kicked or punched) from delivery to 6 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Has client reported any verbal or psychological abuse from delivery to 6 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Frequency of Partner Contact with Infant:
1. ☐ Daily
2. ☐ 2 to 6 times per week
3. ☐ Once per week.
4. ☐ 2 to 3 times per month
5. ☐ Once per month
6. ☐ None
7. ☐ Other
8. ☐ Unknown

Notes/Comments:

Infant Follow-up Birth to 6 Months

Developmental Milestones 5-7 Months:

Laughs out loud without being tickled or touched.	☐ Yes	☐ No
Plays with hands by touching them together.	☐ Yes	☐ No
Holds head upright and steady.	☐ Yes	☐ No
Lifts chest using arms for support.	☐ Yes	☐ No
Rolls over, from stomach to back or vice versa.	☐ Yes	☐ No

Has infant had an acute medical problem from birth to 6 months?

1. ☐ No, no acute medical problem
2. ☐ No, has medical problem, but no treatment
3. ☐ Yes, treatment received
4. ☐ Unknown

Has infant been diagnosed with a chronic medical condition from birth to 6 months?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Abuse/Neglect Report from birth to 6 months:

1. ☐ Yes, initial complaint
2. ☐ Yes, subsequent complaint
3. ☐ No
4. ☐ Unknown

Number of hospitalizations from birth to 6 months:

1. ☐ None
2. ☐ # _____ of times

Number of ER Visits from birth to 6 months:

1. ☐ None
2. ☐ # _____ of times

Is Client Currently Breastfeeding? ☐ Yes ☐ No

If **NO**, how old was the infant when client stopped breastfeeding?

1. ☐ No Breastfeeding
2. ☐ Less Than 1 Week
3. ☐ Between 1 – 5 Weeks
4. ☐ Between 6 – 15 Weeks
5. ☐ Between 16 & 23 Weeks (4 – 6 Months)
6. ☐ Unknown

If Client Stopped or Never Breastfed, What Was/Were the Reasons?

1. ☐ Don't Know How to Breastfeed
2. ☐ Job/Scheduling Difficulties
3. ☐ Mother's Physical/Medical Difficulties
4. ☐ Infant's Physical/Medical Difficulties
5. ☐ Preferred Bottle Feeding
6. ☐ Other: _____
7. ☐ Declined to Respond

Notes/Comments

Date: ___/___/___ (Required) Mother Follow-up 7 to 12 Months Postpartum 23-1

Birth Control Method Use:
1. ☐ Never
2. ☐ Sometimes
3. ☐ Always
4. ☐ No Sexual Activity During This Period- No Partner
5. ☐ No Sexual Activity During This Period- Abstaining
6. ☐ Client Pregnant During Entire Period
7. ☐ Unknown
8. ☐ Declined to Respond

Birth control method use from 7 to 12 months postpartum (mark all that apply)
1. ☐ Condoms w/Spermicide
2. ☐ Condoms w/o Spermicide
3. ☐ Daily Birth Control Pills
4. ☐ Diaphragm/Cervical Cap
5. ☐ Emergency Contraception
6. ☐ Implants (i.e. Norplant)
7. ☐ Injections (i.e. Depo-Provera)
8. ☐ IUC-Intrauterine Contraceptive
9. ☐ Lactational Amenorrhea Method
10. ☐ Patch
11. ☐ Ring
12. ☐ Rhythm/Natural
13. ☐ Sponge/Foam
14. ☐ Tubal Ligation
15. ☐ Vasectomy
16. ☐ Withdrawal
17. ☐ Other: _____
18. ☐ Unknown
19. ☐ Declined to Respond

Has client received treatment for a chronic health problem from 7 to 12 months postpartum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client received treatment for an acute health problem since 7 to 12 months postpartum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems, but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client reported any physical abuse (being hit, slapped kicked or punched) from 7 to 12 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Has client reported any verbal or psychological abuse from 7 to 12 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Frequency of Partner Contact with Infant:
1. ☐ Daily
2. ☐ 2 to 6 times per week
3. ☐ Once per week.
4. ☐ 2 to 3 times per month
5. ☐ Once per month
6. ☐ None
7. ☐ Other
8. ☐ Unknown

Notes/Comments:

Infant Follow-up 7 to 12 Months

Developmental Milestones 11 to 13 Months:

Feeds herself/himself a cookie or cracker.	☐ Yes	☐ No
Tries to reach for toy that is out of reach by stretching arm or body.	☐ Yes	☐ No
Stands up by holding on to a chair or table for thirty seconds or more.	☐ Yes	☐ No
Pulls to a standing position without help.	☐ Yes	☐ No
Makes ma-ma or da-da sounds.	☐ Yes	☐ No

Has infant had an acute medical problem from 7 to 12 months?

1. ☐ No, no acute medical problem
2. ☐ No, has medical problem, but no treatment
3. ☐ Yes, treatment received
4. ☐ Unknown

Has infant been diagnosed with a chronic medical condition from 7 to 12 months?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Abuse/Neglect Report from 7 to 12 months:

1. ☐ Yes, initial complaint
2. ☐ Yes, subsequent complaint
3. ☐ No
4. ☐ Unknown

Number of hospitalizations from 7 to 12 months:

1. ☐ None
2. ☐ # _____ of times

Number of ER Visits from 7 to 12 months:

1. ☐ None
2. ☐ # _____ of times

Is Client Currently Breastfeeding? ☐ Yes ☐ No

If **NO**, how old was the infant when client stopped breastfeeding?

1. ☐ No Breastfeeding
2. ☐ Less Than 1 Week
3. ☐ Between 1 – 5 Weeks
4. ☐ Between 6 – 15 Weeks
5. ☐ Between 16 & 23 Weeks (4 – 6 Months)
6. ☐ Between 24 & 51 Weeks (7 – 12 Months)
7. ☐ Unknown

If Client Stopped or Never Breastfed, What Was/Were the Reasons?

1. ☐ Don't Know How to Breastfeed
2. ☐ Job/Scheduling Difficulties
3. ☐ Mother's Physical/Medical Difficulties
4. ☐ Infant's Physical/Medical Difficulties
5. ☐ Preferred Bottle Feeding
6. ☐ Other: _____
7. ☐ Declined to Respond

Notes/Comments

Date: ___/___/___ (Required) Mother Follow-up 13 to18 Months Postpartum 24-1

Birth Control Method Use:

1. ☐ Never
2. ☐ Sometimes
3. ☐ Always
4. ☐ No Sexual Activity During This Period- No Partner
5. ☐ No Sexual Activity During This Period- Abstaining
6. ☐ Client Pregnant During Entire Period
7. ☐ Unknown
8. ☐ Declined to Respond

Birth control method use from 13 to 18 months postpartum (mark all that apply)

1. ☐ Condoms w/Spermicide
2. ☐ Condoms w/o Spermicide
3. ☐ Daily Birth Control Pills
4. ☐ Diaphragm/Cervical Cap
5. ☐ Emergency Contraception
6. ☐ Implants (i.e. Norplant)
7. ☐ Injections (i.e. Depo-Provera)
8. ☐ IUC-Intrauterine Contraceptive
9. ☐ Lactational Amenorrhea Method
10. ☐ Patch
11. ☐ Ring
12. ☐ Rhythm/Natural
13. ☐ Sponge/Foam
14. ☐ Tubal Ligation
15. ☐ Vasectomy
16. ☐ Withdrawal
17. ☐ Other: _____
18. ☐ Unknown
19. ☐ Declined to Respond

Has client received treatment for a chronic health problem from 13 to 18 months postpartum?

1. ☐ No, client has no health problems
2. ☐ No, client has health problems but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client received treatment for an acute health problem since 13 to 18 months postpartum?

1. ☐ No, client has no health problems
2. ☐ No, client has health problems, but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client reported any physical abuse (being hit, slapped kicked or punched) from 13 to 18 months postpartum?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Has client reported any verbal or psychological abuse from 13 to 18 months postpartum?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Frequency of Partner Contact with Infant:

1. ☐ Daily
2. ☐ 2 to 6 times per week
3. ☐ Once per week.
4. ☐ 2 to 3 times per month
5. ☐ Once per month
6. ☐ None
7. ☐ Other
8. ☐ Unknown

Notes/Comments:

Date: ___/___/___ (Required) Infant Follow-up 13 to 18 Months Postpartum 24-2

Infant Follow-up 13 to 18 Months

Developmental Milestones 13 to 18 Months:

Able to tell you from strangers. ☐ Yes ☐ No
Walks alone or holding on to furniture. ☐ Yes ☐ No
Without help, plays "pat-a-cake" or waves "bye-bye". ☐ Yes ☐ No

Has infant had an acute medical problem from 13 to 18 months?

1. ☐ No, no acute medical problem
2. ☐ No, has medical problem, but no treatment
3. ☐ Yes, treatment received
4. ☐ Unknown

Has infant been diagnosed with a chronic medical condition from 13 to 18 months?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Abuse/Neglect Report from 13 to 18 months:

1. ☐ Yes, initial complaint
2. ☐ Yes, subsequent complaint
3. ☐ No
4. ☐ Unknown

Number of hospitalizations from 13 to 18 months:

1. ☐ None
2. ☐ # _____ of times

Number of ER Visits from 13 to 18 months:

1. ☐ None
2. ☐ # _____ of times

Is Client Currently Breastfeeding? ☐ Yes ☐ No

If **NO**, how old was the infant when client stopped breastfeeding?

1. ☐ No Breastfeeding
2. ☐ Less Than 1 Week
3. ☐ Between 1 – 5 Weeks
4. ☐ Between 6 – 15 Weeks
5. ☐ Between 16 & 23 Weeks (4 – 6 Months)
6. ☐ Between 24 & 51 Weeks (7 – 12 Months)
7. ☐ 52 Weeks or Older (12+ Months)
8. ☐ Unknown

If Client Stopped or Never Breastfed, What Was/Were the Reasons?

1. ☐ Don't Know How to Breastfeed
2. ☐ Job/Scheduling Difficulties
3. ☐ Mother's Physical/Medical Difficulties
4. ☐ Infant's Physical/Medical Difficulties
5. ☐ Preferred Bottle Feeding
6. ☐ Other: _____
7. ☐ Declined to Respond

Notes/Comments

Date: ___/___/___ (Required) Mother Follow - up 19 to 24 Months Postpartum **25-1**

Birth Control Method Use:
1. ☐ Never
2. ☐ Sometimes
3. ☐ Always
4. ☐ No Sexual Activity During This Period- No Partner
5. ☐ No Sexual Activity During This Period- Abstaining
6. ☐ Client Pregnant During Entire Period
7. ☐ Unknown
8. ☐ Declined to Respond

Birth control method use from 19 to 24 months postpartum (mark all that apply)
1. ☐ Condoms w/Spermicide
2. ☐ Condoms w/o Spermicide
3. ☐ Daily Birth Control Pills
4. ☐ Diaphragm/Cervical Cap
5. ☐ Emergency Contraception
6. ☐ Implants (i.e. Norplant)
7. ☐ Injections (i.e. Depo-Provera)
8. ☐ IUC-Intrauterine Contraceptive
9. ☐ Lactational Amenorrhea Method
10. ☐ Patch
11. ☐ Ring
12. ☐ Rhythm/Natural
13. ☐ Sponge/Foam
14. ☐ Tubal Ligation
15. ☐ Vasectomy
16. ☐ Withdrawal
17. ☐ Other: _____
18. ☐ Unknown
19. ☐ Declined to Respond

Has client received treatment for a chronic health problem from 19 to 24 months postpartum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems but has not received treatment
3. ☐ Yes, client has received treatment
4. ☐ Unknown

Has client received treatment for an acute health problem since 19 to 24 months postpartum?
1. ☐ No, client has no health problems
2. ☐ No, client has health problems, but has not received treatment
3 . ☐ Yes, client has received treatment
4. ☐ Unknown

Has client reported any physical abuse (being hit, slapped kicked or punched) from 19 to 24 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Has client reported any verbal or psychological abuse from 19 to 24 months postpartum?
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Frequency of Partner Contact with Infant:
1. ☐ Daily
2. ☐ 2 to 6 times per week
3. ☐ Once per week.
4. ☐ 2 to 3 times per month
5. ☐ Once per month
6. ☐ None
7. ☐ Other
8. ☐ Unknown

Notes/Comments:

Date: ___/___/___ (Required) Infant Follow-up 19 to 24 Months Postpartum 25-2

Infant Follow-up 19 to 24 Months

Developmental Milestones 19 to 24 Months:

Able to walk across a large room without falling. ☐ Yes ☐ No
Indicates what s/he wants without crying or whining. ☐ Yes ☐ No
Can hold a regular cup or glass by himself/herself and drink it without spilling. ☐ Yes ☐ No

Has infant had an acute medical problem from 19 to 24 months?

1. ☐ No, no acute medical problem
2. ☐ No, has medical problem, but no treatment
3. ☐ Yes, treatment received
4. ☐ Unknown

Has infant been diagnosed with a chronic medical condition from 19 to 24 months?

1. ☐ Yes
2. ☐ No
3. ☐ Unknown

Abuse/Neglect Report from 19 to 24 months:

1. ☐ Yes, initial complaint
2. ☐ Yes, subsequent complaint
3. ☐ No
4. ☐ Unknown

Number of hospitalizations from 19 to 24 months:

1. ☐ None
2. ☐ # _____ of times

Number of ER Visits from 19 to 24 months:

1. ☐ None
2. ☐ # _____ of times

Is Client Currently Breastfeeding? ☐ Yes ☐ No

If **NO**, how old was the infant when client stopped breastfeeding?

1. ☐ No Breastfeeding
2. ☐ Less Than 1 Week
3. ☐ Between 1 – 5 Weeks
4. ☐ Between 6 – 15 Weeks
5. ☐ Between 16 & 23 Weeks (4 – 6 Months)
6. ☐ Between 24 & 51 Weeks (6 – 12 Months)
7. ☐ 52 Weeks or Older (12+ Months)
8. ☐ Unknown

If Client Stopped or Never Breastfed, What Was/Were the Reasons?

1. ☐ Don't Know How to Breastfeed
2. ☐ Job/Scheduling Difficulties
3. ☐ Mother's Physical/Medical Difficulties
4. ☐ Infant's Physical/Medical Difficulties
5. ☐ Preferred Bottle Feeding
6. ☐ Other: _____
7. ☐ Declined to Respond

Notes/Comments

BIH-MIS Case Management Care Plan

Intervention Steps

CM Entry/Steps	Dates: MM/DD/YY		Dates: MM/DD/YY
1. Intake	_____/_____/_____	6. Visit Schedule Established	_____/_____/_____
2. Initial Visit	_____/_____/_____	7. Tracking Started	_____/_____/_____
3. Assessment	_____/_____/_____	8. CM Exit Reassessment	_____/_____/_____
4. Goal Setting	_____/_____/_____		
5. Care Plan	_____/_____/_____		

Assessment	Entry	22-26 Weeks Gestation
Creasy Scale Score	_____	_____

Comprehensive Case Management Supplemental Assessment ☐ Completed

Other Comments & Observations:

BIH-MIS Case Management Overview

BIH Entry Information

BIH Entry: _____/_____/_____ **(Required for enrolled Clients)**

Re-Entry Date: _____/_____/_____

Primary Case Manager: _____

BIH Closing Information

BIH Closing Date: _____/_____/_____

Reason:

1. ☐ Service Completed
2. ☐ Client Voluntarily Exited
3. ☐ No Longer Eligible
4. ☐ Moved-No Transfer To Another BIH H.J.
5. ☐ Moved-Transfer To Another BIH H.J.
6. ☐ Unable To Locate/Unresponsive
7. ☐ Death-Index Child
8. ☐ Death-Client
9. ☐ Other _____

Things To Do:

		Date
1.	_____	_____/_____/_____
2.	_____	_____/_____/_____
3.	_____	_____/_____/_____
4.	_____	_____/_____/_____
5.	_____	_____/_____/_____
6.	_____	_____/_____/_____
7.	_____	_____/_____/_____
8.	_____	_____/_____/_____
9.	_____	_____/_____/_____

Positive Reinforcement Words & Statements

_____

_____

_____

_____

Case Management
Intervention/Problem Outcome

Directions:
- Write intervention code # in problem box. Problems are derived from the Comprehensive Assessment.
- Enter numerical Outcome Code in the Outcome at Closure box.
- New problem or intervention at final assessment is any problem or intervention identified after the initial assessment.
- Enter only the primary numerical intervention code.

Outcome Codes
1-Resolved
2-No change
3-Improved but not resolved
4-Condition worse
5-Recurrent
6- N/A
7-New problem at closure

LANGUAGE PROBLEMS	Outcome at Closure
Non-English speaking	

LANGUAGE INTERVENTION CODES	
101	Appropriate language/ materials
102	Referral
199	Other

PERINATAL PROBLEMS	Outcome at Closure
Unresolved perinatal issues	
Medical problems	
No contraceptive plan	
Improper use or problems with chosen birth control method	
Accessing/barriers to health care	
Inadequate knowledge of perinatal care	
Parents don't know teen is pregnant	
No/inadequate exercise	
Using potentially harmful home remedies	
Care safety restraints not used	
Not taking prenatal vitamins as ordered	
Postpartum issues	
Not keeping appointments	
Short interval pregnancy	

PERINATAL INTERVENTION CODES	
201	Perinatal assessment/ education
202	Health promotion
203	Disease process monitoring/education
204	WIC referral/follow-up
205	Routine care referral
206	Develop bureaucracy management strategies
207	MSW referral
208	Encourage/support verbalization of feelings/concerns
209	Encourage health care
210	Facilitate client's informed decision
211	Medication monitoring/ education
212	Loss/grief counseling
213	Provide info on reporting to health care provider
214	Educate how to access/ utilize the system/ services
215	Return demonstration
216	Specialty care referral
217	Encourage MD follow-up
299	Other

NUTRITION PROBLEMS	Outcome at Closure
Inadequate/non-nutritional food	
Inadequate facilities/ equipment for food storage or preparation	
Problems following special diet	
Food/beverage intolerance	
Lack of breast feeding knowledge	
Feeding method undecided	
Lack of knowledge of perinatal dietary needs	
Weight gain problem/ weight loss	
Excessive amounts of caffeinated beverages	

NUTRITION INTERVENTION CODES	
301	Discuss appropriate rate of weight gain
302	Discuss nutrition strength/risks
303	WIC referral/follow-up
304	Educate/counsel regarding perinatal dietary needs
305	Ongoing assessment/ encouragement to meet RDA
306	Instruction on infant feeding problem
307	Encourage/support breast feeding
308	Food referral
399	Other

EMPLOYMENT PROBLEMS	Outcome at Closure
Unemployed	
Limited finances	
Inadequate medical coverage	
Problems with AFDC/ Medi-Cal/Welfare	
Not a high school graduate	
Special learning problems	
Illiterate	
Poor school attendance	
Poor academic performance	
Not in school	
No clear goals for the future	
No child care	

EDUCATION/ EMPLOYMENT INTERVENTION CODES	
401	Support/encouragement
402	Provide information on re-entry programs
403	Client appropriate/ creative teaching methods
404	Skill building tutorial assistance
405	On-campus counseling
406	Self-improvement contract
407	On job safety precautions
408	Assess eligibility and connect with appropriate resources
409	Assist with Medi-Cal application
410	Provide low income housing information
411	Assist client to maximize spending power of available finances
412	Food referral
413	Provide information/ assistance in finding child care
414	Refer to career counseling
415	Refer reentry program
416	Housing referral
499	Other

CURRENT LIVING CONDITIONS PROBLEMS	Outcome at Closure
Moves frequently	
Client doesn't feel safe	
Living with other/lacks own housing	
Children removed from home	
Children living with other family member(s) or friend	
Homeless	
Emergency shelter	
Inadequate housing	
Overcrowded living conditions	

CURRENT LIVING CONDITIONS INTERVENTION CODES	
501	Information/assistance with housing needs
502	Home/neighborhood safety instruction
503	Explore reasons for frequent moves
504	Assist client through family reunification process
505	
506	Ed. re. safety/health risks assoc. with over crowded living conditions
507	Encourage/support verbalization of feelings/concern
508	Housing referral
509	Environmental health referral
510	Women's shelter
599	Other

SUPPORT SYSTEM PROBLEMS	Outcome at Closure
Unstable relationship with father of baby	
Limited or no emotional support	
Other children are unprepared for upcoming birth	
High level conflict in support systems	
Low level of reciprocity	

SUPPORT SYSTEM INTERVENTION CODES	
601	Link with support group/mentor
602	MSW referral
603	Assist client to define actual support system
604	Referral for relationship/personal/ family counseling
605	Support and encourage verbalization of concern/feelings
606	Teach problem solving techniques
607	Conflict resolution
699	Other

EMOTIONAL STATUS PROBLEMS	Outcome at Closure
High stress level	

EMOTIONAL STATUS INTERVENTION CODES	
701	Support/encourage verbalization of feelings

EMOTIONAL STATUS PROBLEMS (Continued)	Outcome at Closure
Emotional problems	
Unresolved psychiatric problems/issues	
History of abuse: physical, sexual, psychological	
Children with history of violence or sexual abuse	
Not comfortable with parenting role	

EMOTIONAL STATUS INTERVENTION CODES (Continued)
702 Provide information/ referral to support groups
703 Counseling
704 File abuse reports
705 MSW referral
706 Parenting education
707 Facilitate change as appropriate
708 Referral to parent education group
799 Other

TRANSPORTATION PROBLEMS	Outcome at Closure
Transportation problems	

TRANSPORTATION INTERVENTION CODES
801 Assist client in identifying transportation resources
802 Transport client
803 Provide bus tokens
804 Teach how to utilize bus system
805 Wean from project provided transportation
899 Other

SUBSTANCE ABUSE PROBLEMS	Outcome at Closure
Smoker	
Alcohol use	
Drug use	
Improper use OTC/ prescription drugs	

SUBSTANCE ABUSE INTERVENTION CODES
901 Smoking referral
902 Alcohol and drugs referral
903 Instruct regarding effect of alcohol, tobacco, drugs & caffeine on mother & fetus
904 Encourage client to eliminate/reduce use
905 Support client in decision to quit/reduce use
906 Encourage client to seek treatment
907 Review/instruct regarding proper use of OTC/prescription drugs
908 Link with mentor
909 Ed. re. recovery process
999 Other

WELL WOMAN PROBLEMS	Outcome at Closure
Declines/problems incorporating the health maintenance schedule into her personal routine	
Lacks adequate preventive health information	

WELL WOMAN INTERVENTION CODES
1001 Preventive health education
1002 Follow-up preventive health implementation plan
1003 Support client in her choices
1004 Disease process monitoring/education
1005 Assessment/education
1099 Other

INFANT PROBLEMS	Outcome at Closure
High risk health condition	
Contraindication to immunizations	
Acute episodic health problem	
Recurrent episodic health problem	

INFANT INTERVENTION CODES
1101 Preventive health education
1102 Disease process monitoring/education
1103 Encourage health care provider follow-up
1104
1105 Administer immunizations

CPS reportable situation		1106 Anticipatory guidance 1107 MSW referral 1108 CPS referral
Immunizations not current		1109 Provide information/ assist in finding child care
No child care		1110 Assessment/education 1111 Routine care referral
Safety concerns		1112 Speciality care referral 1199 Other

STRENGTHS PROBLEMS	Outcome at Closure	STRENGTHS INTERVENTION CODES
Client unable to identify/acknowledge own strengths		1201 Maintenance/support of strengths
		1202 Assist client in identification of own strengths
		1299 Other

SELF-ESTEEM PROBLEMS	Outcome at Closure	SELF-ESTEEM INTERVENTION CODES
Low self-esteem		1301 Promote ego integrity 1302 Acknowledge client successes
PHN assessed low self-esteem		1303 Serve as a role model 1399 Other

COPING MECHANISM PROBLEMS	Outcome at Closure	COPING MECHANISM INTERVENTION CODES
Over reliance on escape/delay action		1401 Encourage/support verbalization of feelings/concerns
Use of smoking & substances to cope		1402 Assist client to define/solve problem
Overeating		1403 Assist client in identifying past useful coping mechanisms
Not eating/anorexia		1404 Facilitate change as appropriate
		1405 Counsel/educate regarding styles
		1499 Other

STRENGTHS - Client Identified _____

_____

STRENGTHS - Staff Identified _____

_____

Assessments Date

Initial _____

Final _____

Client's Name _____ PHN Signature _____

ID# _____

Health Behavior Modification Care Plan

Intervention Milestones Dates:

MM/DD/YY

1. Screening Intake _____/_____/_____
2. Assessment Entry Post Partum
   A. Self-Efficacy Scale _____/_____/_____ _____/_____/_____
   Scores _____ _____
   B . Readiness _____/_____/_____ _____/_____/_____
   Scores _____ _____
   C. Goal Setting _____/_____/_____ _____/_____/_____
3. Intervention Plan Date Started # of Occurrences
   A. Mastery Experience/Reinforcement _____/_____/_____ _____
   B. Verbal Pers/Reinforcement _____/_____/_____ _____
   C. Physio. Resp/Reinforcement _____/_____/_____ _____
   D. Role Modeling/Reinforcement _____/_____/_____ _____
4. Reassessment at Exit _____/_____/_____

Problem Behavior Identification

Scoring: 0 = Not A Problem 2 = Moderate Problem
(Perception) 1 = Minimum Problem 3 = Severe Problem

	Entry		**Exit**		
	Client's Perception	Provider's Perception	Client's Perception	Provider's Perception	# of times Behavior Addressed
1. Drug Use	_____	_____	_____	_____	_____
2. Alcohol Use	_____	_____	_____	_____	_____
3. Smoking	_____	_____	_____	_____	_____
4. No PNC	_____	_____	_____	_____	_____
5. Inconsistent PNC	_____	_____	_____	_____	_____
6. Inadequate nutrition	_____	_____	_____	_____	_____
7. Not obtaining early health care with PTL	_____	_____	_____	_____	_____
8. Poor compliance taking PN vitamins/supplements	_____	_____	_____	_____	_____
9. Inadequate Exercise	_____	_____	_____	_____	_____
10. Inadequate Rest	_____	_____	_____	_____	_____

Client's Overview-Health Behavior Modification

BIH Entry Information

BIH Entry: _____/_____/_____ **(Required for enrolled Clients)** Re-Entry Date: _____/_____/_____

Primary Case Manager: _____

BIH Closing Information

BIH Closing Date: _____/_____/_____

Reason:

1. ☐ Service Completed
2. ☐ Client Voluntarily Exited
3. ☐ No Longer Eligible
4. ☐ Moved-No Transfer To Another BIH H.J.
5. ☐ Moved-Transfer To Another BIH H.J.
6. ☐ Unable To Locate/Unresponsive
7. ☐ Death-Index Child
8. ☐ Death-Client
9. ☐ Other

Things To Do

	Date
1. _____	_____/_____/_____
2. _____	_____/_____/_____
3. _____	_____/_____/_____
4. _____	_____/_____/_____
5. _____	_____/_____/_____
6. _____	_____/_____/_____
7. _____	_____/_____/_____
8. _____	_____/_____/_____

Type of BIH Contact (Circle)

Home Visits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

Office Visits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

Phone Calls: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

Field Visits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

Positive Reinforcement Words & Statements

_____

_____

Social Support & Empowerment Care Plan

Intervention Steps	Dates: MM/DD/YY
1. SSE Screening/Intake	_____/_____/_____
2. Assessment	_____/_____/_____
3. Support Group Sessions	
a. Getting started	_____/_____/_____
b. Culture & self-awareness	_____/_____/_____
c. Self-acceptance & self-expression	_____/_____/_____
d. Self-respect	_____/_____/_____
e. S.S.E. in pregnancy	_____/_____/_____
f. S.S.E. in parenting	_____/_____/_____
g. Self-esteem/empowerment in action	_____/_____/_____
h. Graduation	_____/_____/_____
Additional/Optional Sessions	
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
Total Sessions Attended	_____
4. SSE Exit/Reassessment	_____/_____/_____

CFSEI-2	Entry	Exit
1. General	_____	_____
2. Social	_____	_____
3. Personal	_____	_____
Total	_____	_____
4. Defensiveness	_____	_____

Observational Assessment

Scoring:
5. Excellent - Highest - Most Positive
4. Good
3. Average
2. Marginal
1. Poor - None - Negative - Inappropriate

	Entry	Exit
a) Appearance	_____	_____
b) Dress	_____	_____
c) Communication	_____	_____
d) Helping Behaviors	_____	_____
e) Understanding Goals & Objectives	_____	_____
Total Score	_____	_____

Client's Overview-Social Support & Empowerment 35

BIH Entry Information

BIH Entry: _____/_____/_____ **(Required for enrolled Clients)**

Re-Entry Date: _____/_____/_____

Primary SSE Facilitator: _____

BIH Closing Information

BIH Closing Date: _____/_____/_____

Reason:

1. ☐ Service Completed
2. ☐ Client Voluntarily Exited
3. ☐ No Longer Eligible
4. ☐ Moved-No Transfer To Another BIH H.J.
5. ☐ Moved-Transfer To Another BIH H.J.
6. ☐ Unable To Locate/Unresponsive
7. ☐ Death-Index Child
8. ☐ Death-Client
9. ☐ Other

Things To Do

	Date
1. _____	_____/_____/_____
2. _____	_____/_____/_____
3. _____	_____/_____/_____
4. _____	_____/_____/_____
5. _____	_____/_____/_____
6. _____	_____/_____/_____
7. _____	_____/_____/_____
8. _____	_____/_____/_____
9. _____	_____/_____/_____

Positive Reinforcement Words & Statements

_____

_____

_____

_____

Notes

Notes

Notes

Notes

Client Contacts

Types of Contact: 1 - Phone Call 2 - Office Visit 3 - Field Visit 4 - Mail 5 - Home Visit 6 - Attempted Contact

Model: O - Outreach C - Case Management S - Social Support and Empowerment

Contact Date	Type of Contact	Model	Content/Comments
1. ____/____/____	_____	_____	_____
2. ____/____/____	_____	_____	_____
3. ____/____/____	_____	_____	_____
4. ____/____/____	_____	_____	_____
5. ____/____/____	_____	_____	_____
6. ____/____/____	_____	_____	_____
7. ____/____/____	_____	_____	_____
8. ____/____/____	_____	_____	_____
9. ____/____/____	_____	_____	_____
10. ____/____/____	_____	_____	_____
11. ____/____/____	_____	_____	_____
12. ____/____/____	_____	_____	_____
13. ____/____/____	_____	_____	_____
14. ____/____/____	_____	_____	_____
15. ____/____/____	_____	_____	_____
16. ____/____/____	_____	_____	_____
17. ____/____/____	_____	_____	_____
18. ____/____/____	_____	_____	_____
19. ____/____/____	_____	_____	_____
20. ____/____/____	_____	_____	_____
21. ____/____/____	_____	_____	_____
22. ____/____/____	_____	_____	_____
23. ____/____/____	_____	_____	_____

Client Contacts

Types of Contact: 1 - Phone Call 2 - Office Visit 3 - Field Visit 4 - Mail 5 - Home Visit 6 - Attempted Contact

Model: O - Outreach C - Case Management S - Social Support and Empowerment

Contact Date	Type of Contact	Model	Content/Comments
24. ____/____/____	_____	_____	_____
25. ____/____/____	_____	_____	_____
26. ____/____/____	_____	_____	_____
27. ____/____/____	_____	_____	_____
28. ____/____/____	_____	_____	_____
29. ____/____/____	_____	_____	_____
30. ____/____/____	_____	_____	_____
31. ____/____/____	_____	_____	_____
32. ____/____/____	_____	_____	_____
33. ____/____/____	_____	_____	_____
34. ____/____/____	_____	_____	_____
35. ____/____/____	_____	_____	_____
36. ____/____/____	_____	_____	_____
37. ____/____/____	_____	_____	_____
38. ____/____/____	_____	_____	_____
39. ____/____/____	_____	_____	_____
40. ____/____/____	_____	_____	_____
41. ____/____/____	_____	_____	_____
42. ____/____/____	_____	_____	_____
43. ____/____/____	_____	_____	_____
44. ____/____/____	_____	_____	_____
45. ____/____/____	_____	_____	_____
46. ____/____/____	_____	_____	_____

Client Contacts

Types of Contact: 1 - Phone Call 2 - Office Visit 3 - Field Visit 4 - Mail 5 - Home Visit 6 - Attempted Contact

Model: O - Outreach C - Case Management S - Social Support and Empowerment

Contact Date	Type of Contact	Model	Content/Comments
47. ____/____/____	_____	_____	_____
48. ____/____/____	_____	_____	_____
49. ____/____/____	_____	_____	_____
50. ____/____/____	_____	_____	_____
51. ____/____/____	_____	_____	_____
52. ____/____/____	_____	_____	_____
53. ____/____/____	_____	_____	_____
54. ____/____/____	_____	_____	_____
55. ____/____/____	_____	_____	_____
56. ____/____/____	_____	_____	_____
57. ____/____/____	_____	_____	_____
58. ____/____/____	_____	_____	_____
59. ____/____/____	_____	_____	_____
60. ____/____/____	_____	_____	_____
61. ____/____/____	_____	_____	_____
62. ____/____/____	_____	_____	_____
63. ____/____/____	_____	_____	_____
64. ____/____/____	_____	_____	_____
65. ____/____/____	_____	_____	_____
66. ____/____/____	_____	_____	_____
67. ____/____/____	_____	_____	_____
68. ____/____/____	_____	_____	_____
69. ____/____/____	_____	_____	_____

Client Contacts

Types of Contact: 1 - Phone Call 2 - Office Visit 3 - Field Visit 4 - Mail 5 - Home Visit 6 - Attempted Contact

Model: O - Outreach C - Case Management S - Social Support and Empowerment

Contact Date	Type of Contact	Model	Content/Comments
70. ____/____/____	_____	_____	_____
71. ____/____/____	_____	_____	_____
72. ____/____/____	_____	_____	_____
73. ____/____/____	_____	_____	_____
74. ____/____/____	_____	_____	_____
75. ____/____/____	_____	_____	_____
76. ____/____/____	_____	_____	_____
77. ____/____/____	_____	_____	_____
78. ____/____/____	_____	_____	_____
79. ____/____/____	_____	_____	_____
80. ____/____/____	_____	_____	_____
81. ____/____/____	_____	_____	_____
82. ____/____/____	_____	_____	_____
83. ____/____/____	_____	_____	_____
84. ____/____/____	_____	_____	_____
85. ____/____/____	_____	_____	_____
86. ____/____/____	_____	_____	_____
87. ____/____/____	_____	_____	_____
88. ____/____/____	_____	_____	_____
89. ____/____/____	_____	_____	_____
90. ____/____/____	_____	_____	_____
91. ____/____/____	_____	_____	_____
92. ____/____/____	_____	_____	_____

Client Contacts

Types of Contact: 1 - Phone Call 2 - Office Visit 3 - Field Visit 4 - Mail 5 - Home Visit 6 - Attempted Contact

Model: O - Outreach C - Case Management S - Social Support and Empowerment

Contact Date	Type of Contact	Model	Content/Comments
93. ____/____/____	_____	_____	_____
94. ____/____/____	_____	_____	_____
95. ____/____/____	_____	_____	_____
96. ____/____/____	_____	_____	_____
97. ____/____/____	_____	_____	_____
98. ____/____/____	_____	_____	_____
99. ____/____/____	_____	_____	_____
100. ____/____/____	_____	_____	_____
101. ____/____/____	_____	_____	_____
102. ____/____/____	_____	_____	_____
103. ____/____/____	_____	_____	_____
104. ____/____/____	_____	_____	_____
105. ____/____/____	_____	_____	_____
106. ____/____/____	_____	_____	_____
107. ____/____/____	_____	_____	_____
108. ____/____/____	_____	_____	_____
109. ____/____/____	_____	_____	_____
110. ____/____/____	_____	_____	_____
111. ____/____/____	_____	_____	_____
112. ____/____/____	_____	_____	_____
113. ____/____/____	_____	_____	_____
114. ____/____/____	_____	_____	_____
115. ____/____/____	_____	_____	_____