

Visit for Caregiver/Adult or Child? (Select one)

- Caregiver/Adult
- Child

Which Caregiver/Adult or Child Was Involved (Client Name)?

Date of Activity: _____ / _____ / _____

Population Served: (Select one)

- Prenatal/Pregnant Woman
- Post-Partum Woman
- Woman (18-44 years)
- Infant (< 1 year)
- Child (1-11 years)
- Adolescent (12-22)

Were both parents present for the visit?

- Yes
- No
- N/A - Services for Woman or Adolescent

Setting of Visit: (Select one)

- Home
- Clinic
- School
- Hospital
- Other Community Setting
- Virtual

Is this a Home Visiting Service? (Select one)

- Yes, MCH Home Visit
- Yes, Supplemental Universal Home Visit

If yes, is this client a participant in the KS OD2A Pilot?

- Yes
- No
- No

Provider (Staff or Medical): (Select one)

- Physician
- Physician Assistant
- RN
- APRN/CNM
- LPN
- Licensed Social Worker
- Para-professional (MCH Home Visitor)
- Registered/Licensed Dietitian
- Dentist/Hygienist
- Other

If other, specify: _____

Indicate the number of client's and partner's children in the home age < 1: _____

Indicate the number of client's and partner's children in the home age 1-11: _____

Indicate the number of client's and partner's children in the home age 12-22: _____

SCREENING QUESTIONS

Are you pregnant? (Select One)

- Yes
- No
- N/A-Services for Infant, Child, or Male

If pregnant, when was prenatal care initiated: (Select one)

- 1st Trimester
- 2nd Trimester
- 3rd Trimester
- No PNC initiated

Name of Provider:

Have you given birth within the last year or is this visit for an infant? (Select one)

- Yes - was it a preterm birth? (Select one)
 - Yes
 - No
- No

If yes, are you breastfeeding? (Select one)

- Yes Currently Breastfeeding:
Infant's Date of Birth: _____

- No

If you are not currently breastfeeding, did you initiate breastfeeding at birth? (Select one)

- Yes
- No

If you initiated breastfeeding at birth but are no longer breastfeeding, how long did you exclusively breastfeed?

- | | |
|---|---------------------------------|
| <input type="radio"/> Less than 1 month | <input type="radio"/> 7 months |
| <input type="radio"/> 1 month | <input type="radio"/> 8 months |
| <input type="radio"/> 2 months | <input type="radio"/> 9 months |
| <input type="radio"/> 3 months | <input type="radio"/> 10 months |
| <input type="radio"/> 4 months | <input type="radio"/> 11 months |
| <input type="radio"/> 5 months | <input type="radio"/> 12 months |
| <input type="radio"/> 6 months | |

Has the parent completed a child development screening tool for a child ages 9 months through 35 months, within the past year?

- Yes
- No
- Client is unsure
- N/A - Services for child over 4 years, adolescent or adult

PROGRAM SERVICES

Program Services: (Select all that apply)

- Ages & Stages Questionnaire (ASQ)
- Adverse Childhood Experiences (ACE)
- Allergy Shot
- Blood/Lab Work
- BP/WT/Hgb
- Breastfeeding Assessment
- Breastfeeding Assistance/Counseling
- Car Seat Installation/Check
- Chlamydia Test
- Contraception
- Dental
- Developmental Screening
- Education
- Fetal Heart Tones (FHT)
- Glucose Tolerance Test
- Gonorrhea Test
- Hearing Screening
- High-risk Case Management
- HIV Test
- Immunization
- Injury Prevention
- Kan Be Healthy
- Lead Screening
- Maternal Depression Counseling
- MCH Breast Exam
- MCH Home Visit Education
- MCH Pap Smear
- Other Nursing Assessment
- Other Service/Screening
- Perinatal Mood and Anxiety Disorders
- PHQ-9
- Pregnancy Test
- Prenatal/Post-partum Nursing Assessment
- Sick Visit
- Smoking Cessation 5As/2As & R
- Smoking Cessation Baby & Me Tobacco Free
- Smoking Cessation Counseling
- Smoking Cessation SCRIPT
- Smoking Cessation Other
- Sports Physical
- STD/STI Treatment
- Syphilis Test
- Vision Screening
- Well Adolescent Visit
- Well Child Visit
- Well Infant Visit
- Well Woman Care/ Annual Visit

Specify other service/screening:

Education Provided: (Complete only if education was provided. Select all that apply)

- Alcohol/Substance Abuse
- Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)
- Breastfeeding
- Bullying
- Child Care Resources
- Child Development/Developmental Screening
- Child Protection Information
- Car Seat Safety/Installation
- Continuation of Education
- Count the Kicks
- Family Violence
- Father Involvement
- Food Assistance
- Health Care Coverage/Medicaid Eligibility
- Immunizations
- Infant Care
- Injury Prevention/Safety
- Labor/Childbirth
- Lead Prevention
- Lifestyle risk factors/prenatal exposures
- Maternal Warning Signs
- Medical Home
- Nutrition
- Oral Health
- Parenting
- Perinatal Mood and Anxiety Disorders
- Post-partum care
- Preconception/Interconception
- Prenatal Care
- Preterm Labor
- Reproductive Health/Family Planning
- Safe Sleep
- Smoking Cessation/Second-hand exposure
- State/local resources
- Suicide Prevention
- Teen Pregnancy Prevention
- Transition
- Transportation Assistance
- Utilities Assistance
- Weight Management
- Well Adolescent
- Well Child
- Well Woman
- WIC
- Other **Specify Other Education:**

Was a health risk screening tool administered: (Select all that apply)

- EPDS
- PHQ-9
- PHQ-A
- GAD-7
- ASSIST
- CRAFFT
- AUDIT
- DAST
- Other **Specify Other Education:**

- _____
- N/A – No screening tool administered

Are any referrals needed? (Select one)

- Yes (If yes, fill out the referral form)
- No

Comments:
