

Which Caregiver/Adult was involved (Client Name)?

Date of Activity: ____/____/____

Expected Delivery Date: ____/____/____

New Enrollee?

- Yes
- No

Type of visit:

- Prenatal
- Post-Natal

Pre-Natal Visit Follow Up Questions

Initiated Prenatal Care (PNC):

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

Complied with recommended PNC appointments after initiating care?

- Yes
- No

Post-Natal Visit Follow Up Questions

Attended at least one postnatal (medical) care visit?

- Yes
- No

Date of infant's birth: ____/____/____

Gestational age of infant at birth (in weeks)

- <32 weeks
- 32-27 weeks
- >37 weeks

Multiple Birth?

- Yes
- No

Infant received one-week visit to pediatrician/doctor?

- Yes
- No

Infant placed for adoption?

- Yes
- No

If infant was placed for adoption, date of adoptive placement: ____/____/____

Age of mother at time of adoptive placement:

Fetal/infant death?

- Yes
- No

If yes, date of death: ____/____/____

Age/Time of death?

- Miscarriage
- Fetal death/stillborn
- <7 days
- 7-27 days
- 28-364 days

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 1-11:

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

Number of children in the family who are current on immunizations and Kan Be Healthy (EPSDT):

Direct Services Provided: (Select all that apply)

- Adoption Counseling/Services
- Alcohol/Substance Abuse Services
- Behavioral Health Services
- Budgeting
- Child Care Assistance
- Child Protection Information/Services
- Counseling, other type not specified
- Domestic Violence Information/Services
- Education
- Employment Assistance
- Food Assistance
- Healthcare Coverage Information
- Housing Assistance
- Information about Continuation of Education
- Material Goods
- Maternal Depression Screening
- Parenting Support
- Prenatal Support
- Reproductive Health/Family Planning information
- Smoking Cessation Counseling
- Transportation Assistance
- Utilities Assistance
- Other

Specify Other Service:

Education Provided (Complete only if education was provided):

- 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
- Postpartum 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 provided:

**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

Client completed parent education classes?

- Yes
- No

If yes, date: ____/____/____

During program participation, client enrolled in:

- High School
- GED Program
- Vocation/Technical School
- Community College
- 4-Year College or University
- None

Child Protective Services (CPS) involved with client?

- Yes
- No

If yes, was CPS involvement resolved with custody of children retained by parent?

- Yes
- No

Second pregnancy after enrollment in program?

- Yes
- No

If yes, date pregnancy reported:

____/____/____

Did client complete basic education or vocational goals prior to 2nd pregnancy?

- Yes
- No

Client left the program for the following reason:

- N/A-still participating
- Completed Goals
- Client Terminated Participation
- Miscarriage
- Infant age 12 months
- Client reached age limit (21 years old)
- Client lost Medicaid eligibility
- Client left service area
- Client cannot be located
- Other

Specify Other Reason:

Exit Date: ____/____/____

Are any referrals needed?

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

Notes:
