Kansas Department of Health and Environment DAISEY

PMI Service Form

Which Caregiver/Adult was involved (Client Name)?

_____

Date of Activity: _____/_____/_____

Expected Delivery Date: _____/_____/_____

New Enrollee? (Select one)
- Yes
- No

Type of visit: (Select one)
- Prenatal
- Post-Natal

Pre-Natal Visit Follow Up Questions

Initiated Prenatal Care (PNC): (Select one)
- 1st Trimester
- 2nd Trimester
- 3rd Trimester
- No PNC initiated

Complied with recommended PNC appointments after initiating care? (Select one)
- Yes
- No

Post-Natal Visit Follow Up Questions

Attended at least one postnatal (medical) care visit? (Select one)
- Yes
- No

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

Gestational age of infant at birth (in weeks) (Select one)
- <32 weeks
- 32-27 weeks
- >37 weeks

Multiple Birth?
- Yes
- No

Infant received one-week visit to pediatrician/doctor? (Select one)
- Yes
- No

Infant placed for adoption? (Select one)
- Yes
- No

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

Age of mother at time of adoptive placement:

_____

Fetal/infant death? (Select one)
- Yes
- No

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

Age/Time of death? (Select one)
- 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:

_____

Would you (and/or your partner) like to become pregnant in the next year? (Select one)
- Yes
- No
- Client is unsure
- Client is ok either way

Does the Client Smoke? (Select one)
- Yes
- No

Does anyone else in the household smoke? (Select one)
- Yes
- No

Does the client use other nicotine products? (Select one)
- Yes
- No

Does the client drink alcohol or use other substances? (Select one)
- Yes
- No

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 Post-partum depression)
- Breastfeeding
- Bullying
- Child Development/Developmental Screening
- Car seat safety/installation
- Family Violence
- Father Involvement
- Health Care Coverage/Medicaid Eligibility
- Immunizations
- Infant Care
- Injury prevention/safety
- Labor/Childbirth
- Lifestyle risk factors/prenatal exposures
- Medical Home
- Nutrition
- Oral Health
- Parenting
- Postpartum care
- Postpartum depression
- 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
- Weight Management
- Well Child
- Well Adolescent
- Well Woman
- Other

Specify other education provided:

_____

Client left the program for the following reasons: (Select one)

- N/A-still participating
- Completed Goals
- Client Terminated Participation
- Miscarriage
- Infant age 6 months
- Client left service area
- Client cannot be located
- Other

Specify Other Reason:

_____

Exit Date: _____/_____/_____

Are any referrals needed? (Select one)

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