

Services for Caregiver/Adult or Adolescent?

Caregiver/Adult

Which caregiver was involved? (Client Name) _____

Adolescent

Which caregiver was involved? (Client Name) _____

Date of Activity: _____

Program Client enrolled in:

Family Planning

MCH

PMI

TPTCM

Population served (Select one):

Women (22-44)

Male

Adolescent (12-21)

Have you ever been pregnant and/or delivered a child?

Yes - What was the date your last pregnancy ended/delivered? _____

No

Would you like to become pregnant in the next year?

YES

Educated on:

Birth Spacing

Folic Acid

Health Risks

Referred for pre/interconception care?

Yes - Referred to:

OB/GYN

Family Physician

Safety Net Clinic (FQHC, Rural Health Clinic, income based or free clinic)

MCH Program

Family Planning

Other, please specify: _____

No - Why? Barrier to referral:

No referral source readily available

Inconvenient service times or locations

No Health Insurance

Client cannot afford care

Lack of transportation or childcare

Lack of linguistically or culturally tailored services

Other, please specify: _____

OK EITHER WAY

Educated on:

Birth Spacing

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Other, please specify: _____

Currently on birth control?

Yes - Current method:

IUD

Implant

Depo-Provera

Ring

Patch

Pills

Diaphragm

Condoms (male or female)

Sponge

Spermicide

Cervical Cap

Natural Family Planning/Fertility Awareness

Sterilization (client or partner)

Withdraw

Other, please specify: _____

Discussed current birth control effectiveness, side effects and desired outcome?

Yes

No

Current birth control method changed?

Yes - Reason for Switch

More effective method

Side effects of current method

Cost of current method

Convenience

Other, please specify: _____

No

If not currently on birth control, was a birth control method initiated?

Yes - Type initiated:

IUD

Implant

Depo-Provera

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Patch

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Withdraw

Other, please specify: _____

Client did not want birth control

Why? Please tell us: _____

Referred for birth control initiation

Did client accept the referral for birth control initiation?

Yes - Referred to:

OB/GYN

Family Physician

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Other, please specify: _____

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Inconvenient service times or locations

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Client cannot afford care

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Lack of linguistically or culturally tailored services

Other, please specify: _____

UNSURE

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Other, please specify: _____

Emergency contraception provided:

Yes

No

NA