Kansas Department of Health and Environment

DAISEY

Maternal Child Health Service Form

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** (up to 60 days after the end of pregnancy, includes postpartum children and adolescents)
- ☐ **Woman** (22-44 years, and not pregnant or postpartum)
- ☐ **Infant** (< 1year)
- ☐ **Child** (1-11 years, and not pregnant or postpartum)
- ☐ **Adolescent** (12-22 years, and not pregnant or postpartum)

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?**
    - ☐ Less than 1 month
    - ☐ 1 month
    - ☐ 2 months
    - ☐ 3 months
    - ☐ 4 months
    - ☐ 5 months
    - ☐ 6 months
    - ☐ 7 months
    - ☐ 8 months
    - ☐ 9 months
    - ☐ 10 months
    - ☐ 11 months
    - ☐ 12 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
- ☐ Social Determinants of Health Screen
- ☐ 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 screening tool administered:

_____

- ☐ N/A – No screening tool administered

Are any referrals needed? (Select one)

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

Comments: