Kansas Department of Health and Environment

DAISEY

# TPTCM Service Form

**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
- ☐ Social Determinants of Health Screen
- ☐ 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 screening tool:** _____

- ☐ 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:**