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

Birth weight of infant?
- ○ Less than 3lbs 4oz (1500 grams)
- ○ More than 3lbs 4oz (1500 grams) by less than 5lbs 8oz (2500 grams)
- ○ 5lbs 8oz of more

What type of birth did you have?
- ○ Vaginal
- ○ Cesarean
- ○ VBAC

Did you have a NICU admission?
- ○ Yes
- ○ No

What is the infant's feeding method?
- ○ Breastmilk (breastfeeding/pumping)
- ○ Formula
- ○ Both

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: _____

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 screening tool administered:**

_____

- ☐ N/A – No screening tool administered

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?

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

Notes: