Maternal Child Health Service Form

Visit for Caregiver/Adult or Child? (Select One)
- ☐ Caregiver/Adult
- ☐ Child

Name of Caregiver/Adult Involved? _____

If Child Involved, Name of Child? _____

Date of Activity: _____/_____/_____

Population Served Through the Service: (Select one)
- ☐ Prenatal/Pregnant Woman
- ☐ Post-Partum Woman
- ☐ Woman (18-44 years old)
- ☐ Infant (less than 1 year old)
- ☐ Child (1-11 years old)
- ☐ Adolescent (12-22 years old)

Were both parents present for the visit? (Select one)
(Skip if you selected Woman 18-44 or Adolescent)
- ☐ Yes
- ☐ No

Setting of Visit: (Select one)
- ☐ Home
- ☐ Clinic
- ☐ School
- ☐ Hospital
- ☐ Other Community Setting

Is this a Health Resources and Services Administration (HRSA) Healthy Start Service? (Select one)
- ☐ Yes
- ☐ No

Your Role: (Select one)
- ☐ Physician
- ☐ Physician Assistant
- ☐ RN
- ☐ APRN/CNM
- ☐ LPN
- ☐ Licensed Social Worker
- ☐ Non-Professional
- ☐ Registered/Licensed Dietitian
- ☐ Dentist/Hygienist
- ☐ Other:

_____

Indicate the number of children in the home who are less than 1 year old: _____

Indicate the number of children in the home who are 1-11 years old: _____

Indicate the number of children in the home who are 12-22 years old: _____

SCREENING QUESTIONS*

Are you pregnant? (Select one)
- ☐ N/A- Services for Infant, Child, or Male
- ☐ No
- ☐ Yes — If pregnant, when was prenatal care initiated?
  - ☐ 1st trimester
  - ☐ 2nd trimester
  - ☐ 3rd trimester
  - ☐ No prenatal care prior to delivery

  Name of Prenatal Care Provider: _____

Have you given birth in the last year? (Select one)
- ☐ No
- ☐ Yes — If yes, Babies DOB: _____

  If yes, are you breastfeeding? (Select one)
  - ☐ Yes
  - ☐ No — If you are not currently breastfeeding, did you initiate breastfeeding at birth?
    - ☐ No
    - ☐ Yes

    If yes, you did initiate breastfeeding at birth, but are no longer breastfeeding, how long did you exclusively breastfeed? (# of days, weeks, or months)

    _____

Do you want to become pregnant in the next year? (Select one)
- ☐ Yes
- ☐ No

Do you smoke? (Select one)
- ☐ Yes
- ☐ No

Do you drink alcohol or use other substances? (Select one)
- ☐ Yes
- ☐ No

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* Shaded Questions are also on the Visit Form

Does anyone else in the household smoke? (Select one)

- ☐ Yes
- ☐ No

PROGRAM SERVICES

Visit Type: (Select one)

- ☐ Initial visit
- ☐ Periodic/Follow-up visit

Program Services Provided at this Visit: (Select all that apply)

- ☐ Well woman care/annual visit
- ☐ Prenatal/Post-partum nursing assessment
- ☐ KanBe Healthy
- ☐ Well infant/child/adolescent visit
- ☐ Sick infant/child/adolescent visit
- ☐ Dental
- ☐ Immunization
- ☐ High-risk management
- ☐ Counseling
- ☐ Education
- ☐ Pregnancy test
- ☐ MCH Breast Exam
- ☐ MCH Pap Smear
- ☐ Gonorrhea test
- ☐ Chlamydia test
- ☐ Syphilis test
- ☐ HIV test
- ☐ Developmental screening
- ☐ Perinatal depression screening
- ☐ Lead screening
- ☐ Hearing screening
- ☐ Vision screening
- ☐ Other Service/screening: _____

_____

_____

_____

_____

Education Provided at this Visit: (Select all that apply)

- ☐ 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
- ☐ Post-partum care
- ☐ Post-partum 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/adolescent
- ☐ Well woman/man
- ☐ Other : _____

_____

_____

Are any referrals needed? (Select one)

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

* Shaded Questions are also on the Visit Form