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
- Woman (18-44 years)
- Infant (< 1 year)
- Child (1-11 years)
- Adolescent (12-22)

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 MCH Home Visiting Service? (Select one)
- Yes **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

Would you (and/or your partner) like to become pregnant in the next year? (Select one)
- Yes
- No
- Client is unsure
- Client is ok either way
- N/A - Services for infant or child

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

Does anyone else in the household smoke? (Select one)
- Yes
- No

Do you use other nicotine products?
- Yes
- No

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

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
- Counseling
- 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
- Perinatal Mood and Anxiety Disorders
- MCH Breast Exam
- MCH Home Visit Education
- MCH Pap Smear
- Other Nursing Assessment
- Other Service/Screening
- 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
- 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 Development/Developmental Screening
- Car Seat Safety/Installation
- Count the Kicks
- Family Violence
- Father Involvement
- 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
- Post-partum care
- Perinatal Mood and Anxiety Disorders
- 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
- Weight Management
- Well Child/Adolescent
- 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 Education:**

  _____

- N/A – No screening tool administered

Are any referrals needed? (Select one)

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

Comments:

_____

_____

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