

State ID	Local ID	Last Name	First Name	Middle Name
Date of Birth	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Confidential address? <input type="checkbox"/> Confidential telephone? <input type="checkbox"/> Update to address / telephone?		
Physical Address		Apt. No.	City, Oregon	ZIP

Physical Address Type Home Temporary Homeless No address

Mailing Address (if different from physical address)	Apt. No.	City, Oregon	ZIP
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Mailing Address Type Home Temporary Homeless No address

Primary Telephone No.	Alternate Telephone No.	Guardian Last Name	Guardian MI
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Primary Telephone Type Home Work Message Cellular None

Race / Ethnicity (check all that apply) Hispanic Non-Hispanic

- White Black or African American American Indian or Alaska Native
 Asian Native Hawaiian or Pacific Islander Unknown Other

Spoken Language (preferred)	Written Language (preferred)	Guardian Address (if different from Client's)
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OHP No.	SSN	City, Oregon	ZIP
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Income	Income Interval <input type="checkbox"/> Week <input type="checkbox"/> Bimonthly <input type="checkbox"/> Month <input type="checkbox"/> Annual	Family Size	Concurrent Program Enrollment <input type="checkbox"/> Healthy Start <input type="checkbox"/> WIC <input type="checkbox"/> NFP <input checked="" type="checkbox"/> Babies First <input type="checkbox"/> OMC <input checked="" type="checkbox"/> MCM <input type="checkbox"/> CaCoon
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Insurance <input type="checkbox"/> OHP Standard <input type="checkbox"/> OHP Plus <input type="checkbox"/> CAWEM <input type="checkbox"/> Private <input type="checkbox"/> Military <input type="checkbox"/> Veterans <input type="checkbox"/> Open Card <input type="checkbox"/> None	If no insurance, reason?
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Date Referred / Applied to OHP	OHP Status <input type="checkbox"/> Enrolled <input type="checkbox"/> Referred / Applied <input type="checkbox"/> Refused	Reason if OHP declined coverage <input type="checkbox"/> No Proof <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Covered
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Client's Primary Medical Care Provider	<input type="checkbox"/> None <input type="checkbox"/> Referred <input type="checkbox"/> Refused <input type="checkbox"/> No resource	<input type="checkbox"/> Current with preventive care
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Client's Primary Dental Care Provider	<input type="checkbox"/> None <input type="checkbox"/> Referred <input type="checkbox"/> Refused <input type="checkbox"/> No resource	<input type="checkbox"/> Current with preventive care
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Who referred client to this program? <input type="checkbox"/> WIC <input type="checkbox"/> Babies First! <input type="checkbox"/> Cacoon <input type="checkbox"/> OMC <input checked="" type="checkbox"/> MCM <input type="checkbox"/> Other PH <input type="checkbox"/> Healthy Start <input type="checkbox"/> SafeNet <input type="checkbox"/> NFP <input type="checkbox"/> FP Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> EI <input type="checkbox"/> Self <input type="checkbox"/> Other _____	Perinatal Risk Factors <input type="checkbox"/> <18 years <input type="checkbox"/> Unmarried <input type="checkbox"/> Unplanned Pregnancy <input type="checkbox"/> <HS Education <input type="checkbox"/> IPV <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Nutrition <input type="checkbox"/> Medical Risk (e.g., diabetes, hypertension, obesity) <input type="checkbox"/> Other _____
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Gravida	Term	Preterm	SAB	TAB	Date of First PNC Visit	Trimester Clinical PNC Initiated <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> None	Date LMP	Est. Due Date
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Case Notes

Last Name	First Name	Middle Name	Date of Birth
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Date of Visit	Home Visitor	Case Manager
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Referral to WIC: Referred Refused Getting Services Not Available Not Eligible

Issues / Outcomes

Interventions

Prenatal Care

- Receiving PNC
- Not receiving PNC

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

Breastfeeding

- Has plans for breastfeeding
- No plans for breastfeeding
- Concerns relating to breastfeeding

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement Breastfeeding Assistance Lactation Counseling

HIV Testing & Follow-Up

- Needs HIV testing
- Tested for HIV
- Needs appropriate follow-up

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

Hepatitis B Testing & Follow-Up

- Needs Hepatitis B testing
- Tested for Hepatitis B
- Needs appropriate follow-up

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

Preterm Delivery

- No apparent risk for preterm labor
- At risk for preterm labor
- Receiving treatment for preterm labor

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

Nutrition

- Adequate resources for food
- Inadequate resources for food

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement Behavior Change Nutritional Monitoring

Medical Home for Non-Pregnancy-Related Health Care

- Has medical home
- No medical home

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

Oral Health during Pregnancy

- Adequate dental care
- Inadequate dental care

- Anticipatory Guidance Individual Teaching Case Management Referral
- Support System Enhancement

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Last Name	First Name	Middle Name	Date of Birth
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Issues / Outcomes

Interventions

Intimate Partner Violence (IPV)

<input type="radio"/> No apparent risk for IPV	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	<input type="checkbox"/> Referral
<input type="radio"/> At risk for IPV	<input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Behavior Change		

Alcohol / Substance Abuse

<input type="radio"/> No history of alcohol / substance abuse	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	<input type="checkbox"/> Referral
<input type="radio"/> Recent history (within last year)	<input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Behavior Change		
<input type="radio"/> Current alcohol / substance abuse				

Tobacco Use

<input type="radio"/> No history of smoking	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	<input type="checkbox"/> Referral
<input type="radio"/> Recent history of smoking	<input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> 5 As		

Attempted smoking cessation during the past 12 months <input type="checkbox"/> Yes, no longer smokes <input type="checkbox"/> Yes, didn't stay quit <input type="checkbox"/> No	Smoking frequency <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all	# cigarettes / day (20 = 1 pack)
Other household smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Household smoking rules (inside home at any time / on any occasion) <input type="checkbox"/> No smoking allowed anywhere inside <input type="checkbox"/> Smoking allowed in some rooms <input type="checkbox"/> Smoking permitted anywhere inside	

#1	Date of Delivery	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Birth Weight	Pounds	Ounces	Grams	Birth Length	Inches	Cm
Gestational Age at Birth (weeks)		Breastfeeding started <input type="checkbox"/> Yes <input type="checkbox"/> No		Still Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No					
Age when exclusive breastfeeding stopped <input type="checkbox"/> NA ___ days / ___ weeks / ___ months				Age when formula or solids first introduced <input type="checkbox"/> NA ___ days / ___ weeks / ___ months					
If Pregnancy Outcome Not a Live Birth <input type="checkbox"/> SAB <input type="checkbox"/> TAB <input type="checkbox"/> Stillborn			Date Pregnancy Ended						

#2	Date of Delivery	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Birth Weight	Pounds	Ounces	Grams	Birth Length	Inches	Cm
Gestational Age at Birth (weeks)		Breastfeeding started <input type="checkbox"/> Yes <input type="checkbox"/> No		Still Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No					
Age when exclusive breastfeeding stopped <input type="checkbox"/> NA ___ days / ___ weeks / ___ months				Age when formula or solids first introduced <input type="checkbox"/> NA ___ days / ___ weeks / ___ months					
If Pregnancy Outcome Not a Live Birth <input type="checkbox"/> SAB <input type="checkbox"/> TAB <input type="checkbox"/> Stillborn			Date Pregnancy Ended						

MCM Services and Billing <input type="checkbox"/> G9001 -- Initial Assessment <input type="checkbox"/> G9006 -- Home Assessment <input type="checkbox"/> G9011 -- Telephone Visit <input type="checkbox"/> G9012 -- Case Management Visit <input type="checkbox"/> S9470 -- Nutrition Counseling <input type="checkbox"/> G9002 -- Full Service Case Management <input type="checkbox"/> G9009 -- Partial Service Case Management	Location <input type="checkbox"/> Home <input type="checkbox"/> LHD <input type="checkbox"/> Provider's Office <input type="checkbox"/> Other <input type="checkbox"/> Home <input type="checkbox"/> LHD <input type="checkbox"/> Provider's Office <input type="checkbox"/> Other <input type="checkbox"/> Home <input type="checkbox"/> LHD <input type="checkbox"/> Provider's Office <input type="checkbox"/> Other <input type="checkbox"/> G9005 -- Full Service High Risk Case Management <input type="checkbox"/> G9010 -- Partial Service High Risk Case Management	Date Case Closed (final date of service) Was client lost to follow-up? <input type="checkbox"/> Yes <input type="checkbox"/> No
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