Parent Coach: ____________

Welcome Baby

Prenatal: 28-38 Weeks Home Visit

Date: _____/_____/_____ Length of Visit: ___ hour(s) ____minute(s) Client ID #: _____________

LMP : ______________ EDD: _____/_____/_____ Supervisor: _______________________________

Home Visit Information

Attempted visit #1: ____________ (date) Attempted visit #2: ____________ (date) Attempted visit #3: __________ (date)

Changes in address or phone

Client name: ____ DOB: _____/_____/_____
(First, Middle, Last)

Home address: ____
(Street address, City, State, Zip)

Home phone number: _________________________ Mobile phone number: _______________________

email: ____

If first home visit, collect client consent
Date of Client Written Consent Given: _____/_______/_______ (If no consent given stop here)

Location of Visit:

☐ Client's home ☐ Medical provider office ☐ Home visiting office ☐ Other: ____________________

Who participated in this home visit (select all that apply)?

☐ Mother/Client ☐ Secondary Caregiver/Father ☐ Grandparent ☐ Siblings ☐ Supervisor
___Observation
___Training
___Staff support

☐ Other
If Other, Specify: _________________________________

first 5 la — WELCOME BABY —

Organization Logo

Health Care

Is client covered by any of the following health insurance programs? (select all that apply)

☐ Medi-Cal Presumptive Eligibility ☐ Restricted Medi-Cal ☐ Medi-Cal Managed Care ☐ Full-Scope Medi-Cal

☐ AIM ☐ No health insurance

☐ Private health insurance (List in Case Notes) ☐ Other

If Other, Specify: ______________________________

Medical Provider: ☐ No Medical Provider

Provider name: ______________________________ Clinic's name: ___________________________________

Address: ____

City: ________________ Zipcode: ______________ Phone number: ________________________________

Dental Insurance:

☐ Denti-Cal ☐ Private Dental Coverage ☐ Other Dental Insurance ☐ No Dental Insurance

Dental Status

☐ Client received an exam in the last 12 months. ☐ Client has scheduled an appointment for a dental exam. ☐ Dental referral made by WB. ☐ Client received a referral from elsewhere. ☐ Client opts out of dental services.

Public Benefits

Is client's family receiving any of the following benefits? (select all that apply)

☐ CalWORKs ☐ CalFresh ☐ Homeless Assistance ☐ WIC ☐ SSI/SDI

☐ General Relief ☐ Other ☐ None ☐ Declined to state

If Other, Specify: ______________________

******If needed, please make referral******

Breastfeeding Intent

How does client plan to feed the baby?

☐ Breast only ☐ Breast and formula ☐ Formula only ☐ Not assessed (explain why in notes)

If client intends on breastfeeding, how long does client plan on breastfeeding (in months)? ______________

☐ **Breastfeeding education or support provided?**

****If needed, please make referral****

Home Safety

Home safety risk factors identified?

☐ No Home Safety Assessment Completed
☐ Home Safety Completed, No Risk Factors Found
☐ Tobacco (mother smoking, smoking in home)
☐ Cockroaches, rodents or bed bugs
☐ Possible exposure to lead due to peeling or chipped paint (in home built prior to 1978?)
☐ Occupational exposure to toxins/contaminants
☐ Unsafe objects/substances within infant's reach (sharp or small objects, cleaning products, medications, etc.)
☐ No childproofing (electrical outlets, stairs, cords, pools, etc.)
☐ Weapons kept in home
☐ Drug paraphernalia
☐ Other, please specify: __________

☐ **Home Safety Education provided, if so (*check all that apply*)**

☐ Lead ☐ Second-hand smoking ☐ Sleeping arrangements ☐ Car seat safety ☐ Smoke detectors

☐ Childproofing ☐ Other: ____

****If needed, please make referral****

Depression

Depression screening PHQ-2 completed? ☐ Answered with at least a 1 ☐ Answered all No ☐ Not administered

☐ **Did Not Administer PHQ-9**

PHQ-9 score: ____________

****If depression present, please make referral****

Life Skills Progression

☐ LSP Not Administered

Relationships		Score	Education and Employment		Score
1	Family/Extended Family		12	Language (non-English speaking only)	
2	Boyfriend, FOB, or Spouse		13	<12th Grade Education	
3	Friends/Peers		14	Education	
4	Attitudes in Pregnancy		15	Employment	
5	Nurturing		**Health and Medical Care**		**Score**
6	Discipline		17	Prenatal Care	
7	Support of Development		18	Parent Sick Care	
8	Safety		19	Family Planning	
9	Relationship with Home Visitor		20	Child Well Care	
10	Use of Information		21	Child Sick Care	
11	Use of Resources		23	Child Immunizations	
Mental Health		**Score**	**Basic Needs**		**Score**
24	Substance Use/ Abuse		30	Housing	
25	Tobacco Use		31	Food Nutrition	
26	Depression/Suicide		32	Transportation	
27	Mental Illness		33	Medical/Health Insurance	
28	Self-Esteem		34	Income	
29	Cognitive Ability		35	Child Care	

Other Content Areas Covered

Please indicate whether the following content was covered during the visit. If a specific content area was not discussed or covered, please indicate the reason(s) in your case notes.

- ☐ Assessment of social support and involvement of the secondary caregiver/baby's father
- ☐ Assessment of childbirth knowledge and encouragement of childbirth preparation classes
- ☐ Client's plan for the 1st weeks postpartum, including baby supplies, preparing siblings, help & support from others, etc.)
- ☐ Child Spacing
- ☐ Bonding/Attaching with baby in utero
- ☐ Contraceptive Methods
- ☐ Common pregnancy discomforts and how to alleviate them*
- ☐ Fetal development
- ☐ Importance of prenatal visits*
- ☐ Importance of good oral hygiene and dental visits
- ☐ Kick counts*
- ☐ Nutrition during pregnancy*
- ☐ Normal body changes during pregnancy
- ☐ Substances to avoid during pregnancy*
- ☐ Education About Pregnancy warning signs and preterm labor*
- ☐ Maternal Self Care
- ☐ Self-Care during pregnancy
- ☐ Skin-to-skin

**Content areas are for the first home visit.*

☐ Was time spent on other educational topic(s) not listed above? (List in Case Notes)

Was time spent addressing family crisis or immediate needs of the client?
- ☐ Medical Concerns/Issues for mother or child.
- ☐ Home Environment/Safety
- ☐ Mental Illness
- ☐ Trauma Past/Current (including Domestic Violence, Child Abuse, etc)
- ☐ Basic Needs
- ☐ Resources for other children
- ☐ Other: ____________________________

Are there any concerns or issues that you currently need support with? (List in case notes) **Document Referrals