Parent Coach: _____

Welcome Baby
Postpartum: 2-4 week home visit

Date: _____/_____/_____ Start time: _____ hours _____ minutes Client ID #: _____

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: _____

Location of Visit:

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

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

☐ Newborn ☐ Mother/Client ☐ Secondary Caregiver/Father ☐ Grandparent ☐ Siblings

☐ Supervisor
- ☐ Observation
- ☐ Training
- ☐ Staff support

☐ Other If Other, Specify: _____

If newborn not present for visit, why?

☐ In hospital (explain why in case notes)
☐ Being temporarily cared for by someone else (visit, babysitting)
☐ Permanently in the care of someone else (actual or planned change in custody) other than foster care
☐ Removed from home by DCFS
☐ Infant death (indicate cause in case notes)
☐ Other (explain in case notes)

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 (Enter in Case Notes) ☐ Other: _____

Medical Provider: ☐ No Medical Provider

Provider name: _____ Clinic's name: _____

Address: _____

City: _____ Zipcode: _____ Phone number: _____

☐ **Options on emergency and/or ongoing medical care given?**

6 week postpartum check-up?

☐ Scheduled ☐ Not Scheduled ☐ Attended

Family Planning

Client's current family planning methods and satisfaction.

☐ Family Planning not discussed
☐ Family Planning methods currently not used
☐ Family Planning methods used, but not satisfied
☐ Family Planning methods used and satisfied

☐ **Education provided on Child Spacing**
☐ **Education provided on Contraception**

Public Benefits

Is client receiving any of the following benefits?

☐ CalWORKs ☐ Cal Fresh ☐ Homeless Assistance ☐ WIC ☐ SSI/SDI

☐ General Relief ☐ None ☐ Decline to state ☐ Other: _____

☐ **Information on local food resources provided (WIC, Farmers' Markets, etc.)?**

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

Infant Health Care

Newborn's name: _____ Date of birth: _____/_____/_____

Newborn's gender? ☐ Male ☐ Female

Child Insurance Coverage ☐ **Insurance Card Received**

☐ Medi-Cal- ☐ Healthy Kids ☐ No health insurance

☐ Private health insurance (Enter in Case Notes) ☐ Other: _____

Infant's Medical Provider: ☐ No Medical Provider

Provider name: _____ Clinic's name: _____

Address: _____

City: _____ Zipcode: _____ Phone number: _____

Infant's 3 to 5 day well-baby check up?

☐ Scheduled ☐ Attended ☐ N/A in NICU (different follow up schedule)
☐ Neither Scheduled nor Attended
☐ N/A

Infant's 2 week well-baby check up?

☐ Scheduled ☐ Attended ☐ N/A in NICU (different follow up schedule)
☐ Neither Scheduled nor Attended

☐ **Infant has received the recommended immunizations for their age?** *(Review the record, if possible.)*

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

Emergency Room Visits

How many times has the client been to the hospital emergency room since the last engagement point?

_____

How many times has the baby been to the hospital emergency room since the last engagement point?

_____

****** Explain why in case notes******

Breastfeeding

How is client feeding the baby? *(check all that apply)*

☐ Breast only ☐ Mostly breast, with some formula ☐ Mostly formula, with some breast ☐ Formula only ☐ Other: _____

Solids Introduced? (Check only One)

☐ Not Introduced ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months
☐ 7 Months ☐ 8 Months ☐ 9 Months

Infant feeding education or support provided (check all that apply) ☐ Breastfeeding ☐ Formula Feeding ☐ None

Breastfeeding assistance provided? ☐ Yes ☐ No ☐ Mother exclusively Formula Feeding

If yes, what type: *(check all that apply)*

☐ Latch-on & Positioning ☐ Pumping ☐ Engorgement ☐ Sore nipples ☐ Milk supply

If client stopped breastfeeding, please check the reasons for this: (check all that apply)

☐ Low milk supply ☐ Sore or cracked nipples ☐ Pain ☐ Latch-on difficulties ☐ Medical reason
☐ Return to work ☐ Medication ☐ Lack of support from partner ☐ Lack of support from family ☐ Other: _____

If stopped breastfeeding, how long did client breastfeed?

☐ Less than one week (Check Off) _____ Number of weeks _____ Number of months

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

Home Safety Assessment (if baby in NICU, skip)

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
- ☐ If Other, Specify: _____

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

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

☐ Childproofing ☐ Other: _____

☐ **Home Safety Items Given**

☐ **Family Made a Home Safety Improvement and/or Childproofed the home?**

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

How does client put the baby down to sleep most of the time? (select one)

☐ On his/her side ☐ On his/her back ☐ On his/her stomach

How often does the baby sleep in the same bed with anyone else? (select one)

☐ Always ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

What are the reasons the baby sleeps with another person? (select all that apply)

☐ No crib for baby ☐ Part of culture/tradition ☐ N/A, doesn't bed share

☐ Client wants a closer bond with baby ☐ It is easier to breastfeed baby ☐ Other (Document in Case notes)

☐ **Education provided on safe sleeping**

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

Parent-Infant Interaction Observation

Was positive mother/infant interaction observed? ☐ Yes ☐ No ☐ N/A Baby not present

☐ **Education provided on bonding and secure attachment**

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 (all clients)

☐ **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	

Pre-literacy Activities

Is family engaging in pre-literacy activities? ☐ Yes ☐ No ☐ N/A

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

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 ☐ Education on Newborn care	☐ Infant development and behavior ☐ Maternal Self-Care ☐ Return to work and child care plan support

☐ 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? (Check all that Apply)

☐ 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**