Parent Coach: _____

Welcome Baby
Postpartum: 2 Month Call

Date: _____/_____/_____ Start time: _____ hour(s) _____ minute(s) Client ID #: _____

Supervisor: _____

Visit Information

Attempted call #1: _____ (date) Attempted call #2: _____ (date) Attempted call #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: _____

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's family 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's 2 month 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?

☐ 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 you breastfeed?

☐ Less than one week (check off) _____ Number of weeks _____ Number of months

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

Depression

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

☐ **Did Not Administer PHQ-9**

PHQ-9 score: _____

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

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
- ☐ 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?

- ☐ 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:

_____
__