Parent Coach: ____________________

Welcome Baby
Prenatal: Up to 27 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: ____

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: ____________________________

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Revised 1.9.2015

Organization Logo

Health Care

Is the 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:

If Other, Specify: ________________________________

Medical Provider: ☐ No Medical Provider

Provider name: _______________________________ Clinic's name: ___________________________________

Address: ____

City: ____ 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******

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Organization Logo

Breastfeeding Intent

How does client plan to feed the baby?

☐ Breast only ☐ Breast and formula ☐ Formula only ☐ Not Assessed (explain why in case 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*****

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		8	Language (non-English speaking only	
2	Boyfriend, FOB, or Spouse		9	<12th Grade Education	
3	Friends/Peers		10	Education	
4	Attitudes in Pregnancy		11	Employment	
5	Relationship with Home Visitor		Health and Medical Center		Score
6	Use of Information		12	Prenatal Care	
7	Use of Resources		13	Parent Sick Care	
Mental Health		Score	Basic Needs		Score
14	Substance Use/ Abuse (drugs and/or alcohol)		20	Housing	
15	Tobacco Use		21	Food Nutrition	
16	Depression/Suicide		22	Transportation	
17	Mental Illness		23	Medical/Health Insurance	
18	Self-Esteem		24	Income	
19	Cognitive Ability				

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
- ☐ Bonding/attachment with baby in utero
- ☐ Common pregnancy discomforts and how to alleviate them
- ☐ Education about pregnancy warning signs and preterm labor
- ☐ 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

☐ 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: ____________________________