Parent Coach: _____

Welcome Baby

Prenatal: 20-32 Weeks Call

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

LMP : _____ EDD: _____/_____/_____ Supervisor: _____

Telephone Call 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: _____

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: _____ 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 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******

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)

- ☐ Assessment of childbirth knowledge and encouragement of childbirth preparation classes
- ☐ Assessment of prenatal care
- ☐ Assessment of social support and involvement of the secondary caregiver/baby's father
- ☐ Infant feeding plans and client-centered breastfeeding education

☐ 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 and Child
- ☐ Home Environment/Safety
- ☐ Mental Illness
- ☐ Trauma Past/Current (including Domestic Violence, Child Abuse, etc)
- ☐ Basic Needs
- ☐ Resources for other children
- ☐ Other

If Other, Specify: _____

_____