Parent Coach: ______________________

Welcome Baby- High Risk Non-Best Start Only
Postpartum: 2 Month Home Visit

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

Supervisor: ___________________________________

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 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)

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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/SSD

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

☐ **Information on local food resources provided (WIC, Farmers' Markets, etc.)?**
******If needed, please make referral******

Employment

Employment Status:
☐ Employed Full Time (35 hours plus) ☐ Employed Part Time (20 to 35 hours) ☐ Employed Part Time (less than 20 hours) ☐ Not Employed ☐ Leave of Absence/Disability

Infant Health Care

Newborn's name: ____ Date of birth: ______/______/______

Newborn's gender? ☐ Male ☐ Female

Child Insurance Coverage
☐ Medi-Cal- ☐ Healthy Kids

☐ Private health insurance (Enter in Case Notes)

☐ **Insurance Card Received**
☐ No health insurance
☐ Other:
____

Infant's Medical Provider: ☐ No Medical Provider

Provider name: ______________________________ Clinic's name: __________________________________

Address: ____

City: ___________ Zipcode: ____________________ Phone number: _________________________________

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☐ **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****

Home Safety Assessment

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 item given.**

☐ **Family has made a home safety improvement and/or childproofed the home. If yes, explain in case notes.**

****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
☐ Client wants a closer bond with baby
☐ Part of culture/tradition
☐ It is easier to breastfeed baby
☐ N/A, doesn't bed share
☐ 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******

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? (Check all that apply)

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:

____