Parent Coach: _____

Welcome Baby
Postpartum: 3-4 Month 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)?

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

☐ Supervisor ☐ Newborn ☐ Other: _____
☐ Observation ☐ Training ☐ Staff support

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: _____ ☐ Other: _____

Medical Providers: ☐ 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 Attended ☐ 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/SSD
☐ General Relief	☐ None	☐ Decline to State	☐ Other:_____	

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

Education & 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

Type of Educational program currently enrolled in:

☐ Post-high school vocational certification, technical training ☐ College ☐ Adult school ☐ High school ☐ Middle School or lower

☐ Not enrolled in any program

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: _____ ☐ Other:_____

Infant's Medical Provider: ☐ No Medical Provider

Provider name: _____ Clinic's name: _____

Address: _____

City: _____ Zipcode: _____ Phone number: _____

Infant's 2 month well-baby check up?

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

Infant's 4 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 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 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
☐ 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******

Pre-literacy Activities

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

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

Child Development

☐ **ASQ Not Completed**

Reasons why ASQ Not Completed (Select One)

- ☐ Child not present in home
- ☐ Child Sleeping
- ☐ Child is Ill
- ☐ Child has medical issues which may affect ability to complete
- ☐ Child is premature, delaying the initial ASQ Assessment
- ☐ In home at risk setting, i.e. gang, substance abuse, domestic violence
- ☐ Homeless, guest in home affecting ability to complete assessment or temporary home setting does not allow for visitors
- ☐ Environment in home risk, i.e. filthy, cockroach infestations, bed bugs affecting the ability to conduct the assessment
- ☐ Mother is incarcerated or in a rehabilitation center
- ☐ Other (Enter Reason in Case Notes)

☐ **ASQ Completed**

Select the ASQ Used for this Visit

- ☐ 2 Months
- ☐ 4 Months
- ☐ 6 Months
- ☐ 8 Months
- ☐ 9 Months
- ☐ 10 Months
- ☐ Other (Enter ASQ Administered in Notes)

Was age adjusted for Prematurity when selecting the questionnaire?

☐ Yes ☐ No

ASQ	Score	Above Cutoff	Below Cutoff
1. Communication	_____	☐	☐
2. Gross motor	_____	☐	☐
3. Fine motor	_____	☐	☐
4. Problem solving	_____	☐	☐
5. Personal/Social	_____	☐	☐
6. Regulation	_____	☐	☐

Delay Suspected?

☐ Yes ☐ No

Was a referral for suspected delay made?

☐ Yes ☐ No

If no, reason why referral was not made

☐ Family did not give permission for referral ☐ Other (Enter Reason in Case Notes)

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

☐ 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
- ☐ If Other, Specify: _____