# PRENATAL VISIT ENCOUNTER FORM

Date: (mm/dd/yyyy) ____________ Staff:___________________________
Child's Name: ___________________ HSID: _ _ _ _ -_ _ _ _ -_ _
Current Age:___________ Date of Birth (mm/dd/yyyy)____________
Location of visit: ☐ Home ☐Office ☐ Clinic☐ Hospital ☐Telephone ☐ Other,Specify____________
Length of Visit _____________ Minutes

## Interventions Provided

☐ **Further Assessment/Screening** ☐ Specify_____________________________

- ☐ MRI Screener Specify______________________
- ☐ EPDS (Pop-out Assessment Tool) ☐ Score_________ ☐ Not Competed
- ☐ Education Status Specify______________________
- ☐ Domestic Violence Specify______________________
- ☐ Tobacco Use Specify______________________
  - Is currently smoking ☐ Yes ☐ No
  - If Yes, client is currently pregnant or up to 6 months postpartum? ☐ Yes ☐ No
  - **Action/Response to current smoking:**
  - ☐Delivered clear message about the benefits of quitting smoking
  - ☐Explained and offered SCRIPT
    - ☐Agreed to participate (Go to Script Tab) ☐Declined to participate
  - ☐Client already participating in SCRIPT Go to SCRIPT Tab
  - ☐Referral to Quitline/Hotline (be sure to record in referral section)
  - ☐Other Referral (be sure to record in referral section)
  - ☐Gave hand out/brochure
  - ☐None
- ☐ Substance Abuse Assessment Specify______________________
- ☐ Protective factors Survey (Pop-out Assessment Tool)
- ☐ Other Specify______________________
- ☐ Exit

☐ **Administration of Immunizations,** Specify______________________
☐ **Distribution of Car Seat,** Specify______________________
☐ **Distribution of Breast Pump** Specify______________________
☐ **Transport to Medical/Social Services Appointment**
☐ **Other,** Specify______________________

☐ **Clinical Evaluation:**
☐ Temp: Value:_________________
☐ Pulse: Value:_________________
☐ Respiration: Value:_________________
☐ BP: Value:_________________
☐ Weight: Lbs:__________________
☐ Height: Value:_________________
☐ Blood Glucose Value:_________________

☐ Other Value:________________

☐ **Counseling/Education/Advising:**

☐ First Trimester Pregnancy
☐ Second Trimester Pregnancy
☐ Third Trimester Pregnancy
☐ Alcohol/Drug Use
☐ Asthma
☐ Basic Needs
☐ Behavioral & Emotional Health
☐ Breastfeeding
☐ Child Birth Education
☐ Community Resources (WIC, ect)
☐ Cultural/Spiritual Aspects of Health
☐ Danger Signs/ Complications
☐ Depression
☐ Diabetes (non-GDM)
☐ Domestic Violence
☐ DV Safety Plan Developed
☐ Environmental Risks
☐ Exercise, Rest, Activity
☐ Fetal Growth & Development
☐ Family Planning Methods
☐ Gestational Diabetes
☐ Group Strep/Bacterial Vaginosis
☐ Health Insurance Coverage
☐ HIV/AIDS
☐ Homelessness
☐ Hygiene
☐ Hypertension
☐ Immunizations/Pertussis
☐ Medications
☐ Nutrition
☐ Other, Specify_____________
☐ Overweight/Obesity
☐ Paternity
☐ Peridontal Infection/Dental Caries
☐ Prenatal Care/ Care Schedule
☐ Prenatal Vitamins/Folic Acid
☐ Preterm Labor
☐ Safety, Specify______________
☐ Second Hand Smoke
☐ Sexually Transmitted Infections
☐ Stress Management
☐ Social Health & Support
☐ Tests and Procedures and Follow-up care
☐ Tobacco Use
☐ Underweight
☐ Vaping

**Handouts Provided**

☐ Literature regarding covered education topics
☐ Family Spirit participant Activity Sheets, Specify______________________
☐ Other, Specify_______________________________

☐ **Consult With,** Specify_____________________________

☐ **Other,** Specify_____________________________________

**Referrals**

☐Referral to Specify_________________________________
Purpose_____________________________ Other/Specify:__________________________________
All referrals should have a progess check within 45 days, please enter the date referral progress was checked on (mm/dd/yyyy)__________________
Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
Info Source: ☐ Verified ☐ Self-Report

☐Referral to Specify_________________________________
Purpose_____________________________ Other/Specify:__________________________________
All referrals should have a progess check within 45 days, please enter the date referral progress was checked on (mm/dd/yyyy)__________________
Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
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Purpose_____________________________ Other/Specify:__________________________________
All referrals should have a progess check within 45 days, please enter the date referral progress was checked on (mm/dd/yyyy)__________________
Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
Info Source: ☐ Verified ☐ Self-Report

**Family Spirit Modules:**
**First Lesson Covered**

**(**PC) Prenatal Care specify lesson ________________________________________
(MFM) My Family and Me specify lesson ________________________________________
(HL) Healthy Living specify lesson ________________________________________
IC) Infant Child specify lesson ________________________________________
(YGC) Your Growing Child specify lesson ________________________________________
(TC) Toddler Care specify lesson ________________________________________

**Second Lesson Covered**

| | |
|---|---|
| (PC) Prenatal Care | specify lesson ______________________________________ |
| (MFM) My Family and Me | specify lesson ______________________________________ |
| (HL) Healthy Living | specify lesson ______________________________________ |
| IC) Infant Child | specify lesson ______________________________________ |
| (YGC) Your Growing Child | specify lesson ______________________________________ |
| (TC) Toddler Care | specify lesson ______________________________________ |

NOTES: