

State ID	Local ID	Last Name	First Name	Middle Name
Date of Birth	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Confidential address? <input type="checkbox"/> Confidential telephone? <input type="checkbox"/> Update to address / telephone?		
Physical Address		Apt. No.	City, Oregon	ZIP
Physical Address Type <input type="checkbox"/> Home <input type="checkbox"/> Temporary <input type="checkbox"/> Homeless <input type="checkbox"/> No address				
Mailing Address (if different from physical address)		Apt. No.	City, Oregon	ZIP
Mailing Address Type <input type="checkbox"/> Home <input type="checkbox"/> Temporary <input type="checkbox"/> Homeless <input type="checkbox"/> No address				
Primary Telephone No.		Alternate Telephone No.		Guardian Last Name
Primary Telephone Type <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Message <input type="checkbox"/> Cellular <input type="checkbox"/> None				Guardian First Name
				Guardian MI
Race / Ethnicity (check all that apply) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		Guardian Address (if different from Client's)		
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		City, Oregon		ZIP
<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other		Guardian Type		
Spoken Language (preferred)		Written Language (preferred)		
OHP No.	SSN		Concurrent Program Enrollment	
Income		Income Interval <input type="checkbox"/> Week <input type="checkbox"/> Bimonthly <input type="checkbox"/> Month <input type="checkbox"/> Annual		Family Size
				<input type="checkbox"/> WIC <input checked="" type="checkbox"/> Babies First <input checked="" type="checkbox"/> CaCoon <input checked="" type="checkbox"/> OMC <input checked="" type="checkbox"/> MCM <input type="checkbox"/> Healthy Start <input type="checkbox"/> NFP
Insurance <input type="checkbox"/> OHP Standard <input type="checkbox"/> OHP Plus <input type="checkbox"/> CAWEM <input type="checkbox"/> Private <input type="checkbox"/> Military <input type="checkbox"/> Veterans <input type="checkbox"/> Open Card <input type="checkbox"/> None				If no insurance, reason?
Date Referred / Applied to OHP		OHP Status <input type="checkbox"/> Enrolled <input type="checkbox"/> Referred / Applied <input type="checkbox"/> Refused		Reason if OHP declined coverage <input type="checkbox"/> No Proof <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Covered
Client's Primary Medical Care Provider		<input type="checkbox"/> None <input type="checkbox"/> Referred <input type="checkbox"/> Refused <input type="checkbox"/> No resource		<input checked="" type="checkbox"/> Current with preventive care
Client's Primary Dental Care Provider		<input type="checkbox"/> None <input type="checkbox"/> Referred <input type="checkbox"/> Refused <input type="checkbox"/> No resource		<input checked="" type="checkbox"/> Current with preventive care

Case Start Date	Case Manager
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Who referred client to this program? <input type="checkbox"/> WIC <input type="checkbox"/> Babies First! <input checked="" type="checkbox"/> CaCoon <input type="checkbox"/> OMC <input type="checkbox"/> MCM <input type="checkbox"/> Other PH <input type="checkbox"/> Healthy Start <input type="checkbox"/> SafeNet <input type="checkbox"/> NFP <input type="checkbox"/> FP Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> EI <input type="checkbox"/> Self <input type="checkbox"/> Other _____		Risk Factors / / / / / /	Does client have Early Intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No				
CaCoon Tier		Is this a first birth? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Birth Weight	Pounds	Ounces	Grams	Birth Length	Inches	Cm	Gestational Age at Birth (weeks)

Case Notes

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Visit Date	Home Visitor					
Weight Today	Pounds	Ounces	Grams	Length Today	Inches	Cm

Client's Immunization Status <input type="checkbox"/> Complete or up-to-date (has all recommended shots) <input type="checkbox"/> Delayed (has some of the recommended shots) <input type="checkbox"/> None (has none of the recommended shots) <input type="checkbox"/> Declined / Refused (declines or refuses recommended shots)	# hospitalizations / ER visits in past 6 months Purpose(s) of hospitalization(s) / visit(s)
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Breastfeeding started <input type="checkbox"/> Yes <input type="checkbox"/> No	Still Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Age when exclusive breastfeeding stopped <input type="checkbox"/> NA ___ days / ___ weeks / ___ months	Age when formula or solids first introduced ___ days / ___ weeks / ___ months
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Is client current with specialty care? Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Equipment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Medical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Nutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable PT / OT <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Speech <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable Vision <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Not applicable	Is client current with screening, follow-up, and intervention? Age-appropriate developmental screening (including vision and hearing) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Follow-up, if screening was questionable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Intervention <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
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Issues / Outcomes		Interventions			
Nutrition	<input type="radio"/> Yes Child's nutrition supports adequate growth <input type="radio"/> No	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Nutritional Monitoring	<input type="checkbox"/> Case Management	
Family Knowledge of Chronic Condition	<input type="radio"/> Yes Family is knowledgeable about their child's condition, treatment options, and long-term management needs <input type="radio"/> No	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral <input type="checkbox"/> Normalization Promotion	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Support System Enhancement <input type="checkbox"/> Parenting Promotion	<input type="checkbox"/> Case Management <input type="checkbox"/> Advocacy <input type="checkbox"/> Teaching: Disease Process	
Access to Medical Care	<input type="radio"/> Yes Family has access to medical care and treatment appropriate for their child's condition <input type="radio"/> No	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Advocacy	<input type="checkbox"/> Case Management <input type="checkbox"/> Health System Guidance	
Confidence	<input type="radio"/> Yes Family reports confidence in their ability to meet their child's needs <input type="radio"/> No	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Case Management	
Community Resources	<input type="radio"/> Yes Family is knowledgeable about and is able to access community support and specialized services <input type="radio"/> No	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral <input type="checkbox"/> Sustenance Support	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Case Management <input type="checkbox"/> Advocacy	
Financial Resources	<input type="radio"/> Yes Family has financial resources to cover their child's health care and related expenses <input type="radio"/> No	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Advocacy	<input type="checkbox"/> Case Management <input type="checkbox"/> Sustenance Support	<input type="checkbox"/> Referral	
Safe Sleep Environment	<input type="radio"/> No risk factors identified for sudden death of infant <1 year of age <input type="radio"/> Presence of risk factors for sudden death of infant <1 year of age	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
Parenting	<input type="radio"/> Readiness for enhanced parenting <input type="radio"/> Impaired parenting	<input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Referral <input type="checkbox"/> Attachment Promotion	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Case Management <input type="checkbox"/> Promoting 1st Relationships	

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Issues / Outcomes

Interventions

Oral Health

- No identified dental caries
- At risk for dental caries
- Dental caries

- Anticipatory Guidance
- Referral

- Individual Teaching
- Oral Health Screening

- Case Management
- Fluoride Varnish Application

- No abnormal development
- Secondary condition

- Anticipatory Guidance
- Referral

- Individual Teaching
- Health System Guidance

- Case Management

Tobacco Use

- Client
- MOB / Primary caregiver

- No history of smoking
- Recent history of smoking

- Anticipatory Guidance
- Referral

- Individual Teaching
- Support System Enhancement

- Case Management
- 5As

Attempted smoking cessation during the past 12 months <input type="checkbox"/> Yes, no longer smokes <input type="checkbox"/> Yes, didn't stay quit <input type="checkbox"/> No	Smoking frequency <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all	# cigarettes / day (20 = 1 pack)
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Other household smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Household smoking rules (inside home at any time / on any occasion) <input type="checkbox"/> No smoking allowed anywhere inside <input type="checkbox"/> Smoking allowed in some rooms <input type="checkbox"/> Smoking permitted anywhere inside
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Referrals Out (Check all that apply)	Referral Follow-Up (NA="Not available")	Safety
EI <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Did parents already have info? (Y=yes, N=no) Did you provide information? (P=provided) Implementation reported? (IR)
Immunizations <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Burns / Hot Liquids & Surfaces Y N P IR
Primary Provider <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Car Seat / Seat Belts Y N P IR
SSI <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Falls Y N P IR
TANF / SS <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Gun Safety Y N P IR
WIC <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Helmet Use (bike, scooter) Y N P IR
Other _____ <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Poison Control Y N P IR
Other _____ <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Shaken Baby Syndrome Y N P IR
		Suffocation / Choking Y N P IR

Location Code	Time	<input type="checkbox"/> Submit TCM Claim	Case Closed Date	Reason Case Closed
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