

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 <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other		City, Oregon		ZIP
Spoken Language (preferred)		Written Language (preferred)		Guardian Type
OHP No.	SSN		Concurrent Program Enrollment	
Income	Income Interval <input type="checkbox"/> Week <input type="checkbox"/> Bi-monthly <input type="checkbox"/> Month <input type="checkbox"/> Annual	Family Size	<input type="checkbox"/> WIC <input type="checkbox"/> Babies First <input type="checkbox"/> CaCoon <input type="checkbox"/> OMC <input 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 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 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 checked="" type="checkbox"/> Babies First! <input 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					
	Is this a first birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> IFSP <input type="checkbox"/> IEP					
Birth Weight	Pounds	Ounces	Grams	Birth Length	Inches	Cm	Gestational Age at Birth (weeks)

Case Notes
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Last Name	First Name	Middle Name	Date of Birth
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Visit Date	Home Visitor					
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Weight Today	Pounds	Ounces	Grams	Length Today	Inches	Cm
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<b>Client's Immunization Status</b>			# hospitalizations / ER visits in past 6 months			
<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)			Purpose(s) of hospitalization(s) / visit(s)			

Breastfeeding started	Still Breastfeeding	Age when exclusive breastfeeding stopped		Age when formula or solids first introduced	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NA ___ days / ___ weeks / ___ months		___ days / ___ weeks / ___ months	

Issues / Outcomes	Interventions			
<b>Breastfeeding</b>				
<input type="radio"/> Effective	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> Ineffective	<input type="checkbox"/> Referral	<input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Breastfeeding Assistance	
	<input type="checkbox"/> Lactation Counseling			
<b>Safe Sleep Environment</b>				
<input type="radio"/> No risk factors identified for sudden death of infant <1 year of age	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> Presence of risk factors for sudden death of infant <1 year of age	<input type="checkbox"/> Referral			
<b>Parenting</b>				
<input type="radio"/> Readiness for enhanced parenting	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> Impaired parenting	<input type="checkbox"/> Referral	<input type="checkbox"/> Support System Enhancement	<input type="checkbox"/> Promoting First Relationships	
	<input type="checkbox"/> Attachment Promotion			
<b>Child Development</b>				
<input type="radio"/> Has age-appropriate pattern of development	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> At risk for delayed development	<input type="checkbox"/> Referral	<input type="checkbox"/> Developmental Enhancement	<input type="checkbox"/> RDSI	
<input type="radio"/> Delayed development	<input type="checkbox"/> IMS	<input type="checkbox"/> ASQ	<input type="checkbox"/> Vision	
	<input type="checkbox"/> Hearing	<input type="checkbox"/> Reflexes		
<b>Well-Child Care</b>				
<input type="radio"/> Has medical home	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> No medical home	<input type="checkbox"/> Referral			
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<input type="radio"/> Current with preventive care	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> Not current with preventive care	<input type="checkbox"/> Referral			
<b>Oral Health</b>				
<input type="radio"/> Has oral health home	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> No oral health home	<input type="checkbox"/> Referral			
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<input type="radio"/> No identified risk factors for dental caries	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> At risk for dental caries	<input type="checkbox"/> Referral	<input type="checkbox"/> Oral Health Screening	<input type="checkbox"/> Fluoride Varnish Application	
<input type="radio"/> Dental caries				
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<input type="radio"/> Current with preventive care	<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
<input type="radio"/> Not current with preventive care	<input type="checkbox"/> Referral			

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**Tobacco Use (MOB or Primary Caregiver)**

- No history of smoking     
  Anticipatory Guidance     
  Individual Teaching     
  Case Management  
 Recent history of smoking     
  Referral     
  Support System Enhancement     
  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)
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		

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 <b>Y N P IR</b>
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 <b>Y N P IR</b>
SSI <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Falls <b>Y N P IR</b>
TANF <input type="checkbox"/> Referred <input type="checkbox"/> Refused	<input type="checkbox"/> Getting Services <input type="checkbox"/> NA <input type="checkbox"/> Not eligible	Gun Safety <b>Y N P IR</b>
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) <b>Y N P IR</b>
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 <b>Y N P IR</b>
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 <b>Y N P IR</b>
		Suffocation / Choking <b>Y N P IR</b>

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