/

12 Month/1 Year ASQ:SE Information Summary

Child's name: ______ Child's date of birth: ______

Person filling out the ASQ:SE: ______ Relationship to child: ______

Mailing address: ______ City: ______ State: ______ ZIP: ______

Telephone: ______ Assisting in ASQ:SE completion: ______

Today's date: ______ Administering program/provider: ______

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

   Z (for zero) next to the checked box = 0 points
   V (for Roman numeral V) next to the checked box = 5 points
   X (for Roman numeral X) next to the checked box = 10 points
   Checked concern = 5 points

   Add together:

   Total points on page 3 = ______
   Total points on page 4 = ______
   Total points on page 5 = ______
   Child's total score = ______

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
12 months/1 year	48	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?, Have there been any stressful events in the child's life recently?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

© 2002 Paul H. Brookes Publishing Co.

12 Month ASQ-3 Information Summary

11 months 0 days through 12 months 30 days

Baby's name: ______________________ Date ASQ completed: ______________________

Baby's ID #: ______________________ Date of birth: ______________________

Administering program/provider: ______________________ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	15.64		●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	21.49		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	34.50		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯
Problem Solving	27.32		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	21.73		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

1. Uses both hands and both legs equally well? Yes **NO**
   Comments:
2. Plays with sounds or seems to make words? Yes **NO**
   Comments:
3. Feet are flat on the surface most of the time? Yes **NO**
   Comments:
4. Concerns about not making sounds? **YES** No
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▒ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

______ Provide activities and rescreen in _____ months.

______ Share results with primary health care provider.

______ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

______ Refer to primary health care provider or other community agency (specify reason): ______________________.

______ Refer to early intervention/early childhood special education.

______ No further action taken at this time

______ Other (specify): ______________________

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101120700

Ages & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
© 2009 Paul H. Brookes Publishing Co. All rights reserved.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:________________________ DATE:____________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD© is a trademark of Pfizer Inc.

A2663B 10-04-2005

4

Assessment Template Definition: Antepartum Assessment [Read-only]

Bak | Grp | Srch | Stmt | Dep | Edit | Rem | Up | Dn | Add | Ins | Rep

Minimum Data Set
Documentation Defaults

Template contents

HO Statement Defaults: INITIAL VISIT

- **Antepartum Assessment**
  - Allergy
  - Medications
  - Vital Signs/Body Measurement
  - AP CURRENT PREGNANCY
  - AP PRENATAL CARE
  - AP/PP SUPPORT
  - AP/PP APPEARANCE
  - AP/PP DIABETES
  - AP/PP ENERGY LEVEL/SLEEP PATTERN
  - AP/PP EXTREMITIES
  - AP/PP GI
  - AP UTERUS/VAGINA
  - AP/PP IMMUNIZATION STATUS
  - AP/PP MENTAL/EMOTIONAL
  - AP/PP NUTRITION/EXERCISE
  - AP/PP SUBSTANCE USE
  - AP/PP URINARY SYSTEM
  - AP/PP VISION/HEADACHES/DIZZINESS
  - AP/PP REFERRAL OUTCOME
  - AP/PP REFERRRALS MADE
  - AP HEALTH EDUCATION
  - ADDITIONAL NOTES
  - **INITIAL VISIT**
    - FAMILY INCOME
    - HOME ENVIRONMENT
    - ADULT DOMESTIC VIOLENCE
    - PERIODIC ASSESSMENT PART 1
    - PERIODIC ASSESSMENT PART 2
    - AP HISTORY

Assessment Template Definition: Post Partum/Well-woman Assessment [Read-only]

Bak | Grp | Srch | Stmt | Dep | Edit | Rem | Up | Dn | Add | Ins | Rep

Minimum Data Set
Documentation Defaults

Template contents

HD Statement Defaults: INITIAL ASSESSMENT

- **Post Partum/Well-woman Assessment**
  - AP/PP APPEARANCE
  - Vital Signs/Body Measurement
  - AP/PP VISION/HEADACHES/DIZZINESS
  - PP BREAST/NIPPLES
  - PP C-SECTION
  - AP/PP ENERGY LEVEL/SLEEP PATTERN
  - PP UTERUS/VAGINA
  - AP/PP URINARY SYSTEM
  - AP/PP GI
  - AP/PP EXTREMITIES
  - PP CONTRACEPTION
  - Allergy
  - AP/PP NUTRITION/EXERCISE
  - PP BONDING
  - AP/PP DIABETES
  - AP/PP SUBSTANCE USE
  - ADULT DOMESTIC VIOLENCE
  - AP/PP IMMUNIZATION STATUS
  - Medications
  - AP/PP MENTAL/EMOTIONAL
  - PP HISTORY
  - AP/PP SUPPORT
  - PP PARENTING
  - PP HEALTH EDUCATION
  - AP/PP REFERRRALS MADE
  - AP/PP REFERRAL OUTCOME
  - ADDITIONAL NOTES
  - **INITIAL ASSESSMENT**
    - PERIODIC ASSESSMENT PART 1
    - PERIODIC ASSESSMENT PART 2
    - HOME ENVIRONMENT
    - FAMILY INCOME

Back | Ref | Srch | Stmt | Rx | MinDataSet | Dcmt Dflt | No Change | Close

Assessment Structure

- Current Encounter
- Current Assessment
- **Infant: Birth - 12 Months**
  - APPEARANCE
  - Vital Signs/Body Measurement
  - HEAD AND NECK 1
  - HEAD AND NECK 2
  - CHEST
  - ABDOMEN
  - GENITALIA FEMALE
  - GENITALIA MALE
  - URINE: INFANT
  - STOOL: INFANT
  - NEUROLOGICAL
  - REFLEXES
  - MUSCULOSKELETAL
  - SKIN
  - NUTRITION/FEEDING INFANT 1
  - NUTRITION/FEEDING INFANT 2
  - BONDING - INFANT
  - BONDING - PARENT
  - Allergy
  - Medications
  - IMMUNIZATIONS
  - SUBSTANCE EXPOSURE
  - INFANT ASQ
  - INFANT ASQ-SE
  - BIRTH - 3 MONTHS: MOTOR
  - BIRTH - 3 MONTHS: SOCIAL/EMOTIONAL
  - BIRTH - 3 MONTHS: VISUAL/HEARING
  - 4 TO 7 MONTHS: COGNITIVE
  - 4 TO 7 MONTHS: LANGUAGE
  - 4 TO 7 MONTHS: MOTOR

Contents of 'Infant: Birth - 12 Months'

APPEARANCE

05/18/2011, PHN observes:

APPEARANCE: CLEAN, DRESSED APPROPRIATELY

Back | Ref | Srch | Stmt | Rx | MinDataSet | Dcmt Dflt | No Change | Close

Assessment Structure

- SUBSTANCE EXPOSURE
- INFANT ASQ
- INFANT ASQ-SE
- BIRTH - 3 MONTHS: MOTOR
- BIRTH - 3 MONTHS: SOCIAL/EMOTIONAL
- BIRTH - 3 MONTHS: VISUAL/HEARING
- 4 TO 7 MONTHS: COGNITIVE
- 4 TO 7 MONTHS: LANGUAGE
- 4 TO 7 MONTHS: MOTOR
- 4 TO 7 MONTHS: SOCIAL/EMOTIONAL
- 4 TO 7 MONTHS: VISUAL
- 8 - 12 MONTHS: COGNITIVE
- 8 - 12 MONTHS: LANGUAGE
- 8 - 12 MONTHS: MOTOR MILESTONES
- 8 - 12 MONTHS: SOCIAL/EMOTIONAL
- 8 TO 12 MONTHS: FINE MOTOR
- HEALTH EDUCATION: INFANT CARE
- HEALTH EDUCATION: INFANT DISEASE
- NOTES
- **INITIAL ASSESSMENT**
  - FAMILY INCOME
  - PERIODIC ASSESSMENT PART 1
  - PERIODIC ASSESSMENT PART 2
  - LEAD SCREENING
  - HOME ENVIRONMENT
  - BIRTH HISTORY
  - INFANT/CHILD DOMESTIC VIIOLENCE
- **HRIP REFERRALS / TRACKING**
- HOSPITALIZATION
- SIDS EDUCATION
- PED REFERRALS MADE
- PED REFERRAL OUTCOMES
- **Other Findings**

Contents of 'Other Findings'

PED EDUCATION

05/18/2011, PHN observes

NOTES: Client is not attending preschool at this time Client is waiting to start Kindergarten in the Fall.

4 - 5 YEARS LANGUAGE MILESTONES

05/18/2011, PHN observes.

NOTES. MOC states that she went to a meeting with Brenda Cardoza-SLP, Liz Corona-School Psychologist, and Resource Teacher on 5/12/11 MOC found out that client was not eligible for speech or any special education services through the school MOC states that she believes that the assessment team did not like her and therefore, did not qualify client for special education. PHN explained MOC's rights to appeal their decision if she was not satisfied with results. PHN also advised MOC that she may request for another evaluation in 1 year if interested MOC states that she did not "want to waste any more of my time with those people again." PHN discussed plans to close case per services rendered. MOC agreed to PHN plans.

Back | Ref | Srch | Stml | Rx | MinDataSet | Dcmt Dflt | No Change | Close

Assessment Structure

- Current Encounter
- Current Assessment
- Child: 1 - 5 Years
  - APPEARANCE
  - Allergy
  - Medications
  - SUBSTANCE EXPOSURE
  - IMMUNIZATIONS
  - PED ASQ
  - PED ASQ-SE
  - Vital Signs/Body Measurement
  - SKIN
  - PED EARS
  - PED EYES
  - PED HAIR
  - PED MOUTH AND THROAT
  - PED NUTRITION
  - PED TEETH
  - PED BONES AND JOINTS
  - PED CARDIOVASCULAR
  - PED HEMATOLYMPHATIC
  - PED MUSCLES
  - PED NECK
  - PED NEUROLOGICAL
  - PED RESPIRATORY
  - PED GASTROINTESTINAL
  - PED URINARY
  - PED MALE GENITALIA
  - PEDS FEMALE GENITALIA
  - PED BEHAVIOR
  - SLEEP: INFANT/CHILD
  - PED EDUCATION
  - 1 - 2 YEAR MOTOR MILESTONES

Contents of 'Child: 1 - 5 Years'

APPEARANCE

05/18/2011, PHN observes:

APPEARANCE: CLEAN, DRESSED APPROPRIATELY

PED EDUCATION

05/18/2011, PHN observes:

NOTES: Client is not attending preschool at this time. Client is waiting to start Kindergarten in the Fall.

4 - 5 YEARS LANGUAGE MILESTONES

05/18/2011, PHN observes.

NOTES: MOC states that she went to a meeting with Brenda Cardoza-SLP, Liz Corona-School Psychologist, and Resource Teacher on 5/12/11. MOC found out that client was not eligible for speech or any special education services through the school. MOC states that she believes that the assessment team did not like her and therefore, did not qualify client for special education. PHN explained MOC's rights to appeal their decision if she was not satisfied with results. PHN also advised MOC that she may request for another evaluation in 1 year if interested. MOC states that she did not "want to waste any more of my time with those people again." PHN discussed plans to close case per services rendered. MOC agreed to PHN plans.

Back | Ref | Srch | Stml | Rx | MinDataSet | Dcmt Dflt | No Change | Close

Assessment Structure

- 1 - 2 YEAR MOTOR MILESTONES
- 1 - 2 YEAR COGNITIVE MILESTONES
- 1 - 2 YEARS SOCIAL MILESTONES
- 1 - 2 YEAR FINE MOTOR MILESTONES
- 1 - 2 YEAR LANGUAGE MILESTONES
- 2 - 3 YEAR COGNITIVE MILESTONES
- 2 - 3 YEAR EMOTIONAL MILESTONES
- 2 - 3 YEAR FINE MOTOR MILESTONES
- 2 - 3 YEAR LANGUAGE MILESTONES
- 2 - 3 YEAR MOTOR MILESTONES
- 2 - 3 YEAR SOCIAL MILESTONES
- 3 - 4 YEAR COGNITIVE MILESTONES
- 3 - 4 YEAR FINE MOTOR MILESTONES
- 3 - 4 YEAR LANGUAGE MILESTONES
- 3 - 4 YEAR MOTOR MILESTONES
- 4 - 5 YEAR FINE MOTOR MILESTONES
- 4 - 5 YEAR MOTOR MILESTONES
- 4 - 5 YEARS COGNITIVE MILESTONES
- 4 - 5 YEARS EMOTIONAL MILESTONES
- 4 - 5 YEARS LANGUAGE MILESTONES
- 4 - 5 YEARS SOCIAL MILESTONES
- PED HEALTH EDUCATION
- PED HEALTH EDUCATION: DISEASES
- ADDITIONAL NOTES
- HRIP REFERRALS / TRACKING
  - HOSPITALIZATION
  - PED REFERRALS MADE
  - PED REFERRAL OUTCOMES
  - SIDS EDUCATION
- INITIAL ASSESSMENT
  - PERIODIC ASSESSMENT PART 1
  - PERIODIC ASSESSMENT PART 2
  - LEAD SCREENING

Contents of 'HRIP REFERRALS / TRACKING'

gevue - EMRitus_User

Abuse Assessment Screen

1. Have you ever been emotionally or physically abused by your partner or someone inportant to you? YES NO

2. WITHIN THE LAST YEAR, have you been hit, slapped, kicked or otherwise physically hurt by someone? YES NO

   If YES, by whom? ____________________

   Total number of times ____________________

3. SINCE YOU'VE BEEN PREGNANT, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

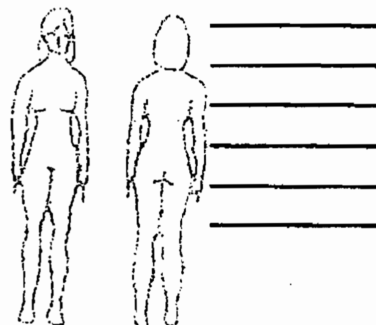
   If YES, by whom? ____________________

   Total number of times ____________________

MARK THE AREA OF INJURY ON THE BODY MAP. SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

SCORE

1 = Threats of abuse including use of a weapon ________
2 = Slapping, pushing; no injuries and/or continuing pain ________
3 = Punching, kicking, bruises, cuts and/or continuing pain ________
4 = Beating up, severe contusions, burns, broken bones ________
5 = Head injury, internal injury, permanent injury ________
6 = Use of weapon; wound from weapon ________



If any of the descriptions for the higher numbers apply, use the higher number.

4. WITHIN THE LAST YEAR, has anyone forced you to have sexual activities? YES NO

   If YES, by whom? ____________________

   Total number of times? ____________________

5. Are you afraid of your partner or anyone listed above YES NO

Client's Name ____________________ D.O.B ____________

Signature & Title ____________________ Initial ____________

Source: Developed by the Nursing Research Consortium on Violence and Abuse

California Medical Training Center
02/18/09

* NOTE: FOR NURSE REFERENCE ONLY.

POTENTIAL DOMESTIC VIOLENCE CUES

PHYSICAL CUES	PSYCHOLOGIAL BEHAVIOR CUES	SOCIAL/FAMILY CUES	CHILDREN'S BEHAVIORS
Vague complaints without physical cause	Increased anxiety in presence of spouse/partner	Home environment "feels tense"	Acting-our violent behavior
Explanation of injury that does not match the injury	Watching spouse/partner for approval of answers to questions	Partner calls home or work environment to "check" on partner	Fearful
Unwarranted delay between time of injury and seeking treatment	"Hovering" partner, over-attentive, intrusive partner, signs of excessive control or extreme jealousy	Alcohol and/or drugs are present	Emotional and physical problems
Minimization of injuries	Partner answers questions	Decisions in household made by partner, controls money or food, e.g., does all grocery shopping	Involved with drug abuse, anorexia (among girls), running away and/or suicide ideation
History of frequent accidents, previous unexplained injuries	Sleep disturbance	History of separations from partner	Poor sleeping habits
Bruises in various stages of healing	Eating disorders	Frequent changes in health care provider	Poor health
Hand print injuries	Substance abuse	Hints of conflict at home	Developmental delays or regressions
Bilateral injuries	Depression	Social isolation	Difficulty separating from parent
Human bites	Suicide attempts or gestures	Frequent unexplained move by family	Acting afraid of men, particularly their father
Soft-tissue injuries of back, stomach, genitals, abdomen, breasts, buttocks, and head, especially neck and face	Low self-esteem such as poor eye contact (ruling out cultural factor), self-depreciating comments	Presence of weapons in home	Acting quiet, looking to parent to speak
Burns	Unexplained fear	Family history of abuse	School problems, frequently moves from school to school or withdrawal from school
Clothes out of season, e.g., long sleeves in summer	Fearful or reluctant to disclose		
	Unusually restricted in activities- may need to "check-in" with partner about activities frequently		

Staff reference only

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

Copyright 2004 Johns Hopkins University, School of Nursing

Corrections to calendar scale 2/3/2010

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage, choking
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following.
("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes **No**

____ ____ 1. Has the physical violence increased in severity or frequency over the past year?
____ ____ 2. Does he own a gun?
____ ____ 3. Have you left him after living together during the past year?
____ ____ 3a. (If have *never* lived with him, check here____)
____ ____ 4. Is he unemployed?
____ ____ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
____ ____ 5a. (If yes, was the weapon a gun?____)
____ ____ 6. Does he threaten to kill you?
____ ____ 7. Has he avoided being arrested for domestic violence?
____ ____ 8. Do you have a child that is not his?
____ ____ 9. Has he ever forced you to have sex when you did not wish to do so?
____ ____ 10. Does he ever try to choke you?
____ ____ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, Meth, speed, angel dust, cocaine, "crack", street drugs or mixtures.
____ ____ 12. Is he an alcoholic or problem drinker?
____ ____ 13. Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car?
____ ____ (If he tries, but you do not let him, check here: ____)
____ ____ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
15. Have you ever been beaten by him while you were pregnant?
____ ____ (If you have never been pregnant by him, check here: ____)
____ ____ 16. Has he ever threatened or tried to commit suicide?
____ ____ 17. Does he threaten to harm your children?
____ ____ 18. Do you believe he is capable of killing you?
____ ____ 19. Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
____ ____ 20. Have you ever threatened or tried to commit suicide?

____ ____ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Instruction for Scoring Revised Danger Assessment

- Add total number of "yes" responses: 1 through 19. ________
- Add 4 points for a "yes" to question 2. ________
- Add 3 points for a "yes" to questions 3 and 4. ________
- Add 2 points for each "yes" to questions 5, 6, and 7. ________
- Add 1 point to each "yes" to questions 8 and 9. ________
- Subtract 3 points if 3a is checked. ________

Total ________

Implications of the Different Levels of Danger on Danger Assessment

Interpretations of Danger Levels

- Less that 8 **(Variable Danger)** – Routine safely planning and monitoring. Inform victim that the level of risk can change quickly and to trust their instincts and to watch for additional signs of danger.
- 8 to 13 **(Increased Danger)** – Safely planning and increased monitoring are important. Advise victim of increased risk and to watch for other signs of danger.
- 14 to 17 (**Severe Danger)** – Advise victim that danger is severe. Be assertive with safely planning; consult with judges, high level of supervision recommendations.
- 18 or more **(Extreme Danger)** – Advise victim of serous danger. Take assertive actions to protect victim – call for criminal justice or other professional help – recommend highest level sanctions for perpetrator such as highest level of probation supervision.

CLIENT NAME: ______________________ **CLIENT ID#:** ______________________

DATE OF SCREENING: __________________ **PHN:** ______________ **PROG:** ______

EDINBURGH POSTNATAL DEPRESSION SCALE

As you are pregnant or recently gave birth, we would like to know how you are feeling. Please circle the answer that best describes how you have felt over the ***past 7 days****, not just how you feel today.*

1. **I have been able to laugh and see the funny side of things.**
   0 = as much as I always could
   1 = not quite as much now
   2 = definitely not so much now
   3 = not at all

2. **I have looked forward with enjoyment to things.**
   0 = as much as I ever did
   1 = less than I used to
   2 = definitely less than I used to
   3 = hardly at all

3. **I have blamed myself unnecessarily when things went wrong.**
   3 = yes, most of the time
   2 = yes, sometimes
   1 = hardly ever
   0 = no, not at all

4. **I have been anxious or worried for no good reason.**
   3 = yes, very often
   2 = yes, sometimes
   1 = hardly ever
   0 = no, not at all

5. **I have felt scared or panicky for no very good reason.**
   3 = yes, quite a lot
   2 = yes, sometimes
   1 = no, not much
   0 = no, not at all

6. **Things have been getting on top of me.**
   3 = yes, most of the time I haven't been able to cope at all
   2 = yes, sometimes I haven't been coping as well as usual
   1 = no, most of the time I have coped quite well
   0 = no, I have been coping as well as ever

7. **I have been so unhappy I have had difficulty sleeping.**
   3 = yes, most of the time
   2 = yes, sometimes
   1 = not very often
   0 = no, not at all

8. **I have felt sad or miserable.**
   3 = yes, most of the time
   2 = yes, quite often
   1 = not very often
   0 = no, not at all

9. **I have been so unhappy that I have been crying.**
   3 = yes, most of the time
   2 = yes, quite often
   1 = only occasionally
   0 = no, never

10. **The thought of harming myself has occurred to me.**
   3 = yes, quite often
   2 = sometimes
   1 = hardly ever
   0 = never

For nursing staff use only

Please check Interval of Administration:

- ☐ **32-36 weeks antepartum**
- ☐ **6-8 weeks postpartum**
- ☐ **PRN**
- ☐ **OB Provider Referral**
- ☐ **MSW Referral**

TOTAL SCORE: __________

Client Age: ______

Source: Reprinted, with permission from Cox JL, Holden JM, Sagovsky R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

Key
X= Problem (See Nursing Notes)
O= No problem identified / reported
I= Instruction / Anticipatory Guidance

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
INFANT FLOWSHEET

DATE								
OBJECTIVE DATA								
Infants age								
Temperature								
Pulse								
Respiration								
Weight								
Length								
Head Circumference								
Fontanels								
Mouth / Teeth								
Skin								
Abdomen-Umbilicus								
Genitalia								
Upper Extremities								
Lower Extremities								
Newborn Reflexes								
General Appearance								
SUBJECTIVE DATA								
Urine Output (per day)								
Stool Output (per day)								
Intake Fluids (B-F)								
a. Ounces / Frequency								
Intake Solids (C-F-V-M-E)								
APPTS (Date / K-M)								
Well Child Exam								
Immunizations Only								
Sick Infant Exam								
ER / Specialists								

Chart # ______________

Page # ____

Key
X= Problem (See Nursing Notes)
I=Instruction/Anticipatory guidance
----- = Not Addressed

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
INFANT RISK FACTOR / INSTRUCTION FLOWSHEET

DATE								
SIDS								
Safety								
Growth and Development								
S/Sx of Sick Child								
Temperature Technique								
Food / Fluid Introduction								
Feeding Technique								
Positioning / Stimulation								
Bath / Hygiene								
Bonding								
Lead Prevention								
Compliance with WCE / IZ								
Other (if applicable)								
Referral Offered (C/ N / R):								
Referral Offered (C/ N / R):								
Case Manager Initials								

Key
X= Problem (See Nursing Notes)
O= No problem identified / reported
I= Instruction / Anticipatory Guidance
---= Not Addressed

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Health Education Services Toddler Flowsheet

DATE								
OBJECTIVE DATA								
Toddlers age								
Temperature								
Pulse								
Respiration								
Weight								
Length								
Mouth/Teeth								
Abdomen								
Skin								
General Appearance								
SUBJECTIVE DATA								
Stool Output (per day)								
Intake Fluids								
a. Milk Ounces / Frequency								
b. Juice Ounces/ Frequency								
APPTS (Date / K-M)								
Well Child Exam								
Immunizations Only								
Sick Infant								
ER / Specialists								

Chart # ____________

Page # ______

Key
X= Problem (See Nursing Notes)
I=Instruction/Anticipatory Guidance
O=No problem identified/reported
----= Not Addressed

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Health Education Services Flow Sheet

DATE								
Interconceptional Care								
Well Woman Care								
Safety								
Growth and Development								
Nutrition								
a. Meat								
b. Vegetables								
c. Fruit								
d. Healthy Snacks								
Discipline								
Parenting/Nurturing								
Potty Training								
Weaning to Cup								
Playtime								
Immunizations								
Other (if applicable)								
Referral Offered (C/ N / R):								
Referral Offered (C/ N / R):								
Case Manager Initials								

Key
X= Problem (See Nursing Notes)
O= No problem identified / reported
I=Instruction / Anticipatory Guidance
----- = Not Addressed

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
WELL WOMEN ASSESSMENT / RISK FACTOR & INSTRUCTION FLOWSHEET

DATE								
OBJECTIVE DATA (X,O, or --)								
Temperature								
Pulse								
Respiration								
B/P								
Weight								
General Appearance								
Emotional State								
RISK FACTOR/INST. (X, I, or --)								
Contraception/Interconceptional Care								
Tobacco / ETOH / Drugs								
STI / HIV								
Pap Smears / Yearly P.E								
Breast Self Exam								
Dental Health								
Vision								
Safety / Environmental Hazards								
Nutrition								
Exercise								
Parenting / Bonding								
Stress Management								
Domestic Violence								
Compliance with Well Woman Care								
Other: (if applicable)								
APPOINTMENTS (DATE/ K-M)								
Medical / Dental / Specialty								
Birth Control								
WIC								
Referral Offered (C / N / R):								
Referral Offered (C / N / R):								
Case Managers Initials								

Chart # ______________
Page # ______________

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management

WELL WOMEN ASSESSMENT / RISK FACTOR & INSTRUCTION FLOWSHEET

DATE								
OBJECTIVE DATA (X,O, or --)								
Temperature								
Pulse								
Respiration								
Blood Pressure								
Weight								
General Appearance								
Emotional State								
INSTRUCTION (X,I, or --)								
Contraception/Interconceptional Care								
Tobacco / ETOH / Drugs								
STI / HIV								
Pap Smears / Yearly P.E								
Breast Self Exam								
Dental Health								
Vision								
Safety / Environmental Hazards								
Nutrition								
Exercise								
Parenting / Bonding								
Stress Management								
Domestic Violence								
Compliance with Well Woman Care								
Other: (if applicable)								
APPOINTMENTS (DATE/ K-M)								
Medical / Dental / Specialty								
Birth Control								
WIC								
Referral Offered (C / N / R):								
Referral Offered (C / N / R):								
Case Managers Initials								

Page # ____________

Rev. May 2008

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
ANTEPARTUM FLOWSHEET

Key
X= Problem (See Nursing Notes)
O= No problem identified / reported
I= Instruction / Anticipatory Guidance

Client Antepartum Summary

Gestation (wks) PNC began:_________ Gestation (wks) at CCM entry : ________ LMP ___________ EDC ____________

Dates of PNC appt prior to CCM: ____

Height __________ Pre-Pregnancy Weight __________ Planned Delivery Hospital ________________________________

DATE							
OBJECTIVE DATA							
Gestation (wks)							
Temperature							
Pulse							
Respiration							
Blood Pressure							
Weight							
Edema							
General Appearance							
Emotional State							
SUBJECTIVE DATA							
Nausea/Vomiting							
Bleeding/ Cramping							
Abdominal Pain							
Shortness of Breath							
Headache/Blurred vision							
Backache							
Vaginal Discharge							
Painful/Frequent Urination							
Undue Fatigue							
APPTS (Date / K or M)							
OB/GYN							
OB/GYN							
OB/GYN							
Labs / US / NST							
Sick / ER / Other:							
WIC							

Chart # ____________________

Comprehensive Case Management

ANTEPARTUM RISK FACTOR / INSTRUCTION FLOWSHEET

Key

X= Problem (See Nursing Notes)

I= Instruction / Anticipatory guidance

----- = Not Addressed

Date							
Febrile Episode / S&Sx of Infection							
Fetal Development							
Physiological / Emotional Changes							
Common Complaints of Pregnancy							
Nutrition / Foodborne Risks							
Rest / Exercise							
Level of Stress							
Accident Prevention / Safety							
Substance Use / ETOH / Tobacco							
Sexual Relations / STI's & HIV							
Depression / Other MH Conditions							
Domestic Violence							
Environmental Exposures							
Dental Care							
Fetal Kicks Count (after 24 wks)							
SIDS (after 28 wks)							
Breastfeeding (after 28 wks)							
Prep for L&D/Baby (after 28 wks)							
Contraception (after 28 wks)							
Compliance with Prenatal Care							
Other: (if applicable)							
Referral Offered (**C**=Completed / **N**=Not Completed / **R**=Refused):							
Referral Offered (**C**=Completed / **N**=Not Completed / **R**=Refused):							
Referral Offered (**C**=Completed / **N**=Not Completed / **R**=Refused):							
Case Manager Initials							

ANTEPARTUM RISK FACTORS

[Note: Do not fill out this page for New Postpartum clients]

Key
0 – Negative (Risk Prevention Counseling)
X – Positive (Risk Reduction Counseling)
R – Referred for further assessment/treatment
TX – Already in treatment
RR - Refused Referral/Treatment
CR – Completed referral

Date Screened:							
RISK FACTOR							
Group B Strep or Bacterial Vaginosis							
HIV/AIDS							
Other STI/STDs							
Smoking							
Alcohol							
Illicit Drugs							
Depression							
Other Mental Health Problems							
Domestic Violence							
Homelessness							
Overweight & Obesity							
Underweight							
Hypertension							
Gestational Diabetes							
Peridontal Infection							
Asthma							
Family History of Breast Cancer							
SCREENING TOOLS USED							
Edinburgh (score)							

Key
X= Problem (See Nursing Notes)
O= No problem identified / reported
I= Instruction / Anticipatory Guidance

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
POSTPARTUM FLOWSHEET

Client Intrapartum – Delivery / Postpartum Summary

Delivery (circle): NVD / NVD with Epis / CS Hospital: Length of Stay:

Complications:

DATE				
OBJECTIVE DATA				
Temperature				
Pulse				
Respiration				
Blood Pressure				
Weight				
Edema				
General Appearance				
Emotional State				
SUBJECTIVE DATA				
Breasts				
Breastfeeding				
Lochia				
Episiotomy / Incision				
Pain				
Bowel / Bladder				
Emotional Well Being				
Fatigue				
Calf Tenderness				
General Health				
APPT (Date / K or M)				
Post Partum Check-Up				
Medical / Vision / Dental				
WIC				

Chart # ______

Key
X= Problem (See Nursing Notes)
I=Instruction/Anticipatory guidance
----- = Not Addressed

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
Comprehensive Case Management
POSTPARTUM RISK FACTOR / INSTRUCTION FLOWSHEET

DATE				
P.P Complications				
P.P. Blues / Depression				
Accessing Support Systems				
Physiological Changes				
Fatigue / Rest				
Nutrition				
Exercise				
Bonding				
Parenting				
Hygiene				
Sexual Relations				
Contraceptive Methods				
Interconceptional Care				
Illicit Drug /ETOH /Tobacco				
Domestic Violence				
Compliance with PP Care				
Other (if applicable)				
Referral Offered (C=Completed / N=Not Completed / R=Refused):				
Referral Offered (C=Completed / N=Not Completed / R=Refused):				
Referral Offered (C=Completed / N=Not Completed / R=Refused):				
Case Manager Initials				

Infant/Toddler HOME
Bettye M. Caldwell and Robert H. Bradley
Summary Sheet

Family name ______________________ Date _______ Visitor ______________

Address ______________________ Phone ______________

Child's name ______________________ Birth date __________ Age ____ Sex ____

Interviewee______________ If other than parent, relationship to child ______________

Family composition ______________________
(persons living in household, including sex and age of children)

Family ethnicity ______________ Language spoken ______________ Maternal education ________ Paternal education __________

Is mother employed? _______ Type of work when employed? ______________ Hrs/Wk ________

Is father employed? _______ Type of work when employed? ______________ Hrs/Wk ________

Current child care arrangements ______________________

Summarize past year's arrangements ______________________

Other person(s) present during visit ______________________

Notes ______________________

____

SUMMARY

Subscale	Possible Score	Median	Actual Score	Comments
I. RESPONSIVITY	11	9		
II. ACCEPTANCE	8	6		
III. ORGANIZATION	6	5		
IV. LEARNING MATERIALS	9	7		
V. INVOLVEMENT	6	4		
VI. VARIETY	5	3		
TOTAL SCORE	45	32		

Copyright 2003.

Planning For a Healthy Future Questionnaire

22

he purpose of this questionnaire is to help you think about areas in which you could improve your health. Being healthy is not only good for you but als ncreases your chances of having a healthy baby should you become pregnant again. Please complete the following questionnaire and afterwards, we can tal bout information that might be helpful to you. You can ask me any questions you may have at any time.

arent Name:____________________ **Referred by:**____________________

ate of Birth:____________________ **Referred to:**____________________

ate of Birth of Last Child:____________________

1. Family Planning/Birth Spacing (Check and specify all that apply, not all questions may be applicable)

- ☐ Do you hope to have any more children?
- ☐ If yes, how many more children do you hope to have?__________
- ☐ If yes, how long would you like to wait until you become pregnant again? __________
- ☐ If no, how are you preventing future pregnancies? __________

2. In a past birth or pregnancy, have you ever experienced? (Check all that apply)

- ☐ Complications in pregnancy
- ☐ A still birth
- ☐ Reoccurring pregnancy loss
- ☐ A child with a developmental disability
- ☐ Cesarean section
- ☐ A pre-term birth (before 37 weeks)
- ☐ A low weight baby (less than 5.5 lbs.)

3. Your Health and Your Next Pregnancy: Do you? (Check and specify all that apply)

- ☐ Ever smoke cigarettes?
- ☐ Drink alcoholic drinks (beer, wine, etc)?
- ☐ Use recreational drugs like cocaine, meth, or marijuana?
- ☐ Take prescriptions or over the counter drugs?
- ☐ Take herbal remedies or supplements?
- ☐ Follow a particular diet?
- ☐ Eat less than 3 meals a day or fast?
- ☐ Take folic acid?
- ☐ Breastfeed?
- ☐ Know your Body Mass Index? Ht __________ Wt __________
- ☐ Do you exercise? Type__________ How long?__________ How often?__________

4. Health Services (Check and specify all that apply)

- ☐ Do you have medical coverage?
- ☐ Do you have a regular primary care physician?
- ☐ Have you seen your doctor in the last year?
- ☐ Have you seen a dentist in the last year?
- ☐ When was your last HIV test? __________

5. Your Medical History: Do you have/have you ever had? (Check and specify all that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Kidney or bladder disorders
- ☐ Thyroid Disease
- ☐ Chicken Pox
- ☐ Hepatitis B
- ☐ Depression or other mental health issues
- ☐ Surgery
- ☐ Arthritis/Lupus
- ☐ Cancer
- ☐ Hypothyroidism
- ☐ Maternal Phenylketonuria
- ☐ Recurring vaginal infections
- ☐ STD:__________
- ☐ Other:__________

6. Have you, your partner or someone in either family had/or ever experienced? (Check and specify all that apply)

	You	Partner	Other family
Hemophilia or other bleeding disorders	☐	☐	☐
Tay Sachs or Jewish Background	☐	☐	☐
Blood Diseases (sickle cell or thalassemia)	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Down Syndrome/Mental Retardation	☐	☐	☐
Cystic Fibrosis	☐	☐	☐
Birth Defects:__________	☐	☐	☐
Developmental Disability	☐	☐	☐
High Blood Pressure	☐	☐	☐
Diabetes	☐	☐	☐

7. Have you been vaccinated for? (Check all that apply)

- ☐ Hepatitis B
- ☐ Human Papillomavirus (HPV)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Seasonal Flu
- ☐ Tetanus, Diphtheria, Pertussis (Tdap)
- ☐ Varicella (Chicken Pox)

8. Environmental Hazards: Do you? (Check all that apply)

- ☐ Work near/live with someone who smokes?
- ☐ Have a cat?
- ☐ Work/Live near potential hazards (lead, chemicals, x-ray or radiation)?
- ☐ Work/Live with someone who works in an automotive shop, dry cleaning business, gas station, or something of that nature?

9. Emotional Wellbeing (Check all that apply)

- ☐ During the past month, have you often been bothered by feeling down, depressed, or hopeless?
- ☐ During the past month, have you often been bothered by having little interest or pleasure in doing things?
- ☐ Does anyone hurt you physically or emotionally or threaten to do so?
- ☐ During the past few months, have you felt emotionally supported most of the time?
- ☐ During the past few months, have your friends and relatives helped you when you needed it?

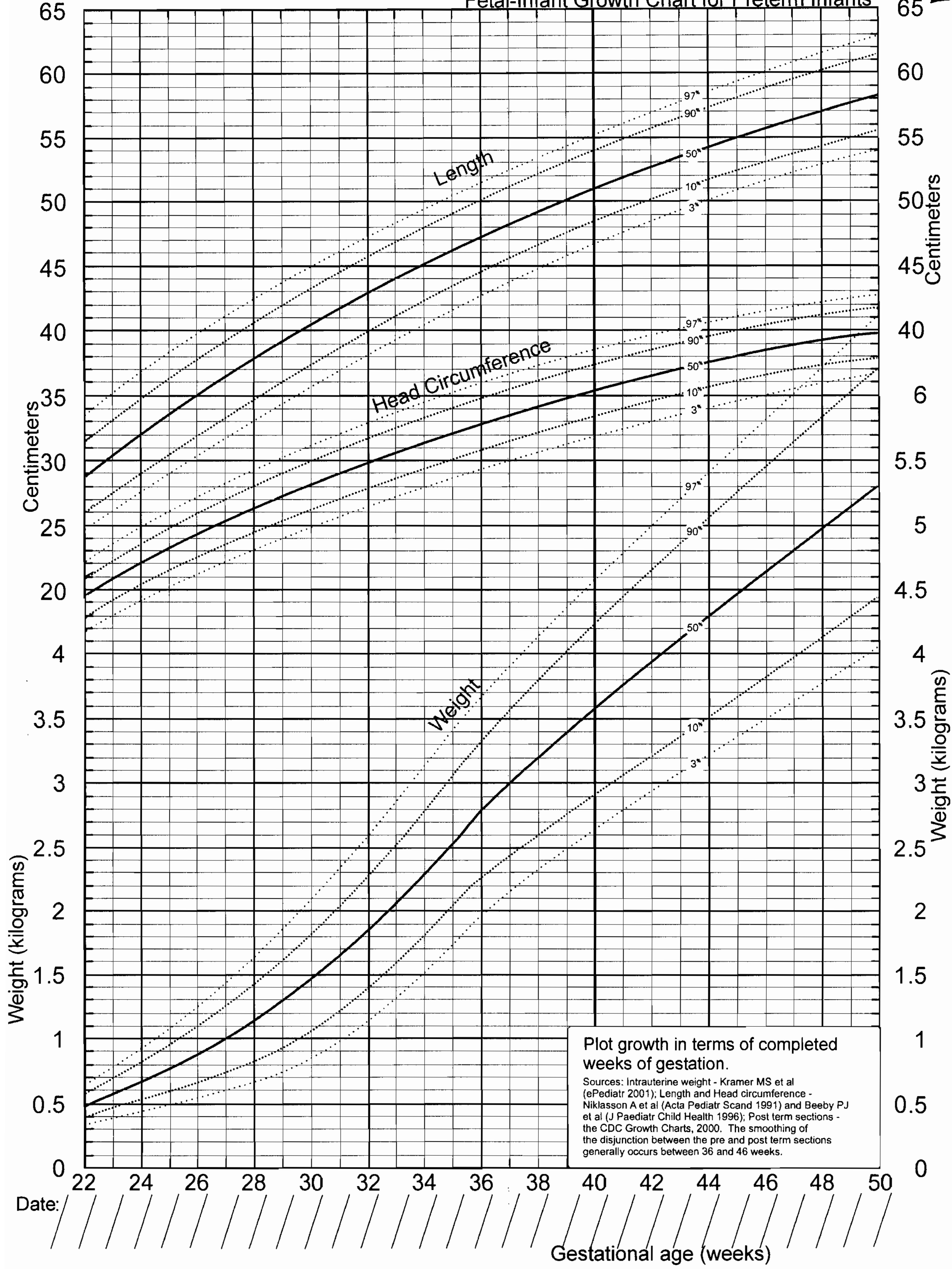
Birth to 24 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME ____________________

RECORD # ____________

Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)



24
Fetal-Infant Growth Chart for Preterm Infants
Length
Head Circumference
Weight
97%
90%
50%
10%
3%
Centimeters
Weight (kilograms)
Gestational age (weeks)
Date:
65
60
55
50
45
40
35
30
25
20
6
5.5
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
22
24
26
28
30
32
34
36
38
40
42
44
46
48
50
Plot growth in terms of completed weeks of gestation.
Sources: Intrauterine weight - Kramer MS et al (ePediatr 2001); Length and Head circumference - Niklasson A et al (Acta Pediatr Scand 1991) and Beeby PJ et al (J Paediatr Child Health 1996); Post term sections - the CDC Growth Charts, 2000. The smoothing of the disjunction between the pre and post term sections generally occurs between 36 and 46 weeks.

Mother's Ethnic Heritage (See back page)	Length of Time Feeding (*circle minutes*)	☐ No	Quiet Sleep	Active Sleep	Drowsy
Marital/Partner Status ☐ Married ☐ Single	10 or Less 11-19 20-29 30 or more	If yes, specify________	Quiet Alert	Active Alert	Crying

I. SENSITIVITY TO CUES

	YES	NO
1. Caregiver positions child so that child is safe but can move his/her arms.		
2. Caregiver positions child so that the child's head is higher than hips.		
3. Caregiver positions child so that trunk-to-trunk contact is maintained during more than half of the breast or bottle feeding (50%).		
4. Caregiver positions child so that eye-to-eye contact is possible.		
5. Caregiver's face is at least 7-8 inches or more from the child's face during feeding except when kissing, caressing, hugging, or burping the child.		
6. Caregiver smiles, verbalizes, or makes eye contact with child when child is in open-face-gaze position.		
7. Caregiver comments verbally on child's hunger cues prior to feeding.		
8. Caregiver comments verbally on child's satiation cues before terminating feeding.		
9. Caregiver varies the intensity of verbal stimulation during feeding.		
10. Caregiver varies intensity of rocking or moving the child during the feeding.		
11. Caregiver varies the intensity or form of touch during the feeding.		
12. Caregiver allows pauses in feeding when the child shows potent disengagement cues or is in the pause phase of the suck-pause sequence of sucking.		
13. Caregiver slows the pace of feeding or pauses when child shows subtle disengagement cues.		
14. Caregiver terminates the feeding when the child shows satiation cues or after other methods have proved unsuccessful.		
15. Caregiver allows child to suck and/or chew without interruption.		
16. Caregiver only offers food when the child is attending.		
TOTAL YES ANSWERS		

II. RESPONSE TO CHILD'S DISTRESS

☐ Yes ☐ No (Potent Disengagement Cues Observed)

	YES	NO
17. Caregiver stops or starts feeding.		
18. Caregiver changes the child's position.		
19. Caregiver makes positive or sympathetic verbalization.		
20. Caregiver changes voice volume to softer or higher pitch.		
21. Caregiver makes soothing non-verbal efforts.		
22. Caregiver diverts child's attention by playing games, introducing toy, or making faces.		
23. Caregiver avoids making negative verbal responses.		
24. Caregiver avoids making negative comments to home visitor about child.		
25. Caregiver avoids yelling at child.		
26. Caregiver avoids using abrupt movements or rough handling.		
27. Caregiver avoids slapping, hitting, or spanking the child.		
TOTAL YES ANSWERS		

III. SOCIAL-EMOTIONAL GROWTH FOSTERING

	YES	NO
28. Caregiver pays more attention to child during feeding than to other people or things in the environment.		
29. Caregiver is in "en face" position for more than half of the feeding.		
30. Caregiver succeeds in making eye contact with child once during feeding.		
31. Caregiver's facial expression changes at least twice during feeding.		
32. Caregiver engages in social forms of interaction (plays games with child) at least once during the feeding.		
33. Caregiver uses positive statements in talking to child during the feeding.		
34. Caregiver praises child or some quality of the child's behavior during the feeding.		
35. Caregiver hums, croons, sings or changes the pitch of his/her voice during the feeding.		
36. Caregiver laughs or smiles during the feeding.		
37. Caregiver uses gentle forms of touching during the feeding.		
38. Caregiver smiles, verbalizes or touches child within five seconds of child smiling or vocalizing at caregiver.		
39. Caregiver avoids compressing lips, grimacing, or frowning when making eye contact with child.		
40. Caregiver avoids slapping, hitting, shaking, or grabbing the child or child's extremities during the feeding.		
41. Caregiver avoids making negative comments or uncomplimentary remarks to the child or home visitor about the child or child's behavior.		
TOTAL YES ANSWERS		

IV. COGNITIVE GROWTH FOSTERING

	YES	NO
42. Caregiver provides child with objects, finger foods, toys, and/or utensils.		
43. Caregiver encourages and/or allows the child to explore the breast, bottle, food, cup, bowl, utensils, or the caregiver during feeding.		
44. Caregiver talks to the child using two words at least three times during the feeding.		
45. Caregiver verbally describes food or feeding situation to child during feeding.		
46. Caregiver talks to child about things other than food, eating, or things related to feeding.		
47. Caregiver uses statements that describe, ask questions or explains consequences of behavior, more than commands, in talking to child.		
48. Caregiver verbally responds to child's sound within five seconds after child has vocalized.		
49. Caregiver verbally responds to child's movement within five seconds of child's movement of arms, legs, hands, head, trunk.		
50. Caregiver avoids using baby talk.		
TOTAL YES ANSWERS		

NCAST FEEDING SURVEY TOOL P.1

has begun.		
54. Child has periods of alertness during the feeding.		
55. Child displays at least two different emotions during the feeding.		
56. Child has periods of activity and inactivity during the feeding.		
57. Child's movements are smooth and coordinated during the feeding.		
58. Child's arm and leg movements are generally directed toward caregiver during feeding (not diffuse).		
59. Child initiates contact with caregiver's face or eyes at least once during feeding.		
60. Child vocalizes during feeding.		
61. Child smiles or laughs during feeding.		
62. Child averts gaze, looks down or turns away during feeding.		
63. Child actively resists food offered.		
64. Child demonstrates satiation at end of feeding.		
65. Child has less than three rapid state changes during feeding.		
TOTAL YES ANSWERS		

VI. RESPONSIVENESS TO CAREGIVER

66. Child responds to feeding attempts by caregiver most of the time.		
67. Child responds to games, social play or social cues of caregiver during feeding.		
68. Child looks in the direction of the caregiver's face after caregiver has attempted to alert the child verbally or non-verbally during feeding.		
69. Child vocalizes to caregiver during feeding.		
70. Child vocalizes or smiles within five seconds of caregiver's vocalization.		
71. Child smiles at caregiver during feeding.		
72. Child explores caregiver or reaches out to touch caregiver during feeding.		
73. Child shows a change in level of motor activity within five seconds of being handled or repositioned by caregiver.		
74. Child shows potent disengagement cues during last half of feeding.		
75. Child shows potent disengagement cues within five seconds after caregiver moves closer than 7 to 8 inches from child's face.		
76. Child avoids turning away from caregiver, or averting gaze during first half of feeding.		
TOTAL YES ANSWERS		

Copyright © 1994 by Kathryn Barnard, University of Washington, School of Nursing, Seattle. All Rights Reserved. Printed in the USA.

NOTICE: IT IS ILLEGAL TO PHOTOCOPY OR OTHERWISE REPRODUCE THIS ASSESSMENT WITHOUT THE PUBLISHERS WRITTEN PERMISSION.

To use this scale for research or clinical practice requires training. For more information write or call:
NCAST-AVENUW Programs
University of Washington
Box 357920
Seattle, WA 98195-7920
Phone 206-543-8528
www.ncast.org

RESPONSE TO DISTRESS	11		6	
SOCIAL-EMOTIONAL GROWTH FOSTERING	14		1	
COGNITIVE GROWTH FOSTERING	9		2	
CAREGIVER TOTAL	**50**		**15**	
CLARITY OF CUES	15		0	
RESPONSIVENESS TO CAREGIVER	11		3	
INFANT TOTAL	**26**		**3**	
CAREGIVER/INFANT TOTAL	**76**		**18**	

Check the Potent Disengagement Cues (PDC's) observed during the feeding interaction (excluding initial tension up to a minute into the feeding and any PDC's that terminate the feeding).

___ Back arching
___ Choking
___ Coughing
___ Crawling away
___ Cry face
___ Crying
___ Fussing
___ Halt hand
___ Lateral head shake
___ Maximal lateral gaze aversion
___ Overhand beating movements
___ Pale/red skin
___ Pulling away
___ Pushing away
___ Saying "no"
___ Spitting
___ Spitting up
___ Tray pound
___ Vomiting
___ Walking Away
___ Whining
___ Withdraw from alert to sleep state

Ethnic Heritage. Place a checkmark next to the mother's ethnic heritage and write in her specific group identity.

___ African-American
___ Asian Indian or A.I.- American
___ Chinese or Chinese-American
___ Filipino or Filipino-American
___ Japanese or Japanese-American
___ Korean or Korean-American
___ Pacific Islander or P.I.- American
___ Vietnamese or Vietnamese-American
___ Other Asian
___ Cuban or Cuban-American
___ Mexican, Chicano, or Mex. American
___ Puerto Rican
___ Other Hispanic/Latin
___ Native American or Alaskan Native
___ White/Caucasian (non-Hispanic)
___ Other

Specific group identity:___________________

Clinical Notes:

Date of Observation ___________________

Recorder's Signature ___________________

1/96

P. 2

PEI Self Chart Audit

Client Name: ______________________________ **Client #:** ____________

Forms	Required Time Frame for Completion	Yes	No	Documentation why not done or NA Please comment	Form Signed and Initialed by PHN	SPHN
Flap 1						
Home Visit (NSR)						
Comprehensive Nursing Assessment						
Abuse Assessment Screen						
Calendar 2011-2012						
Danger Assessment						
Acknowledgement of Receipt						
Authorization For use and Disclosure –Perinatal Program						
Authorization For Use and Disclosure-Behavioral Health						
Consent for Treatment						
Flap 2						
Family Data Base						
Medication Flowsheet						
Antepartum Flowsheet						
Postpartum Flowsheet						
Well Women Assessment / Risk Factors & Instruction Flowsheet						
Infant Data Base						
Infant Flowsheet						
Development Assessment Flowsheet						

PHN Signature: ______________________________ Date Reviewed: ______________________

SPHN Signature: ______________________________ Date: ______________________

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY
TIMESTUDY SURVEY FOR FFP PROGRAM CLAIMING

DEPARTMENT OF HEALTH SERVICES

Period (Mo/Yr): November 2010

EMPLOYEE NAME	POSITION/TIMESHEET #	PERSONNEL CLASSIFICATION	AGENCY/ENTITY	UNIT NAME
Kelley Kathleen	26	Public Health Nurse II	Fresno County-Public Hlth.	MCAH
				LOCATION

Program Coding Scheme

A - 1700 - BIH	C - 1710 - West Fresno Nursing	E - 1677 - Child Care Health Linkages	G - Other (1748, 1500, 1501, 5600, etc.)
B - 1706 - MCH	D - 1719 - Nurse Family Partnership	F - 1670 - High Risk Infant Program	H -

Date	CC #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hrs
1 Outreach	1700																																
	1706																																
2 SPMP Admin. Medical Case Management	1700																																
	1706																																
3 SPMP Intra/Interagency Coord., Collab. and Admin.	1700																																
	1706																																
4 NON-SPMP Intra/Interagency Coord., Collab. and Admin.	1700																																
	1706																																
5 Program Specific Administration	1700																																
	1706																																
6 SPMP Training	1700																																
	1706																																
7 NON-SPMP Training	1700																																
	1706																																
8 SPMP Program Planning and Policy Development	1700																																
	1706																																
9 Quality Management by Skilled Med. Personnel	1700																																
	1706																																
10 Non-Program Specific General Administration	1700																																
	1706																																
11 Other Activities	1700																																
	1706																																
	Other																																
12 Paid Time Off	1700																																
	1706																																
	Other																																
Daily Total Hrs	1700																																
	1706																																
	Other																																

Enhanced (Codes 2+3+6+8+9)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog. C ____ Prog. G ____
Prog. D ____ Prog. H ____

Paid Time Off (Code 12)
Total- ____

Non-Enhanced (Codes 1+4+5+7)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog. C ____ Prog. G ____
Prog. D ____ Prog. H ____

Non-Prog Specific Administration (Code 10)
Total- ____

Non-Claimable (Code 11)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog. C ____ Prog. G ____
Prog. D ____ Prog. H ____

EMPLOYEE I hereby certify that this is a true and accurate report of my time and that the functions were performed as shown above

Employee's Signature ____ Date ____

SUPERVISOR I hereby certify that the employee's time records have been examined and that, to the best of my knowledge and belief, this time record is valid and correct and the functions were performed as shown above

Supervisor's Signature ____ Date ____

Weekly Time Study for Title V 30/30 Earmarking

Position #: ____
Name: ____
Job Title: ____
Location: Fresno, CA 93721
Agency: Fresno County Dept. Of Public Health
Subcontractor: ____

Time Study Period (Week/Date): September 5-9, 2011

% FTE ____

Date: 9/5/11	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	Total Hrs.	
																									0	#1
																									0	#2
																									0	#3

Date: 9/6/11	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	Total Hrs.	
																									0	#1
																									0	#2
																									0	#3

Date: 9/7/11	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	Total Hrs.	
																									0	#1
																									0	#2
																									0	#3

Date: 9/8/11	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	Total Hrs.	
																									0	#1
																									0	#2
																									0	#3

Date: 9/9/11	7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30	5:00	5:30	6:00	6:30	Total Hrs.	
																									0	#1
																									0	#2
																									0	#3

Categories	Day 1	Day 2	Day 3	Day 4	Day 5	TOTALS	%
1. Preventive & Primary Care Services for Children (PPCSC)	0	0	0	0	0	0	#DIV/0!
2. Children with Special Health Care Needs (CSHCN)	0	0	0	0	0	0	#DIV/0!
3. * Other	0	0	0	0	0	0	#DIV/0!

*** Note: If you appear on your Agency's MCAH Budget and are performing AFLP, BIH, FIMR, BIH/FIMR, and/or SIDS activities you should report the time spent performing these activities under Category 3 - Other.**

I hereby certify that this is a true and accurate report of my time and that the categories were performed as shown above.

I hereby certify that the employee's time records have been examined and that, to the best of my knowledge, this time record is valid and correct and the categories were performed as shown above.

Employee's Signature ____ *Date* ____

Supervisor's Signature ____ *Date* ____

28

(09/10)

County Auto Mileage Log

Car Number: ___________ Month/Year ___________________

Date	Employee	Odometer		Purpose of Trip	Destination (if home visit, indicate client/Avatar #)	Total Miles
		Start	End			
Total Mileage						

Private Auto Mileage Log

Employee: ______________________ Month/Year: ___________

Date	Odometer		Purpose of Trip	Destination (if home visit, indicate client/Avatar #)	Total Miles*
	Start	End			
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total Mileage					0

*Total will be automatically calculated when entered electronically.

Updated 6/13/2011

MATERNAL, CHILD, AND ADOLESCENT HEALTH
BABIES FIRST MIS DATA COLLECTION
DEMOGRAPHICS

Client ID (Avatar #): ______________ BF/MIS Episode #____________ (MCAH Clerical)

Last Name: ________________________ First Name: ___________________________

Address: ____

City: __________________ Zip: ______________ Census Tract: ______________

Client DOB: _____________ Health Start CT ☐

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other

Primary Language: ☐English ☐Hmong ☐Laotian ☐Spanish ☐Other _______________________

ESL: ☐Yes ☐No

Household Income: (update household income at least once a year or when you know it changes)	# in Household:	Date:
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________

Payor Source: **(Update if it changes During pregnancy)**

☐Medi-Cal (Full Scope)
☐Medi-Cal Applied
☐Presumptive Eligibility
☐Pregnancy Only Medi-Cal
☐Other ____________________

☐Healthy Families
☐AIM
☐Private Insurance
☐Self Pay

Date Updated:
____
____
____
____

Source of Referral: (choose only one)

☐ PH Nursing Services Referral
☐ CPSP Provider Referral
☐ CCM for 2nd Year Tracking
☐ Other
☐ **Subsequent Pregnancy**

Referral Date: _______________ (This is date received by MCAH [stamped], **date informed of subsequent pregnancy** or date transferred to 2nd Year Tracking)

DEMOGRAPHICS (Continued)

Disposition (Program): (Choose only one)

☐ Comprehensive Case Management- West Fresno
☐ Nurse Family Partnership
☐ Care Coordination – 1 year / 2 year
☐ 2nd Year Tracking

Case Manager/Care Coordinator Assigned: ______________________

Date Case Opened (Signed Consent): ___________________

Client enrolled as a new participant during what period? (Check one only that applies) ☐Antepartum ☐Postpartum

Date Closed to Service: ______________ Closure Code: ______
(Or lost to follow-up)

Choose only one of the following for Closure Codes: [Select the most appropriate]

1. Services completed
2. Lost to follow-up
3. Unable to locate [when you cannot locate client or they get lost to follow-up]
4. No longer eligible [when client falls into these categories: SAB, TAB, low risk, not pregnant, transfer to tracking, incarcerated]
5. Client voluntarily exited [when client decides to no longer participate in the program and exits]
6. Moved out of Fresno County
7. Transfer to another program or already in another program
8. Death of Child
9. Death of Client
10. Refused/declined services [when client is first offered services]
11. Other [use if nothing else applies to your client/must discuss with your Supervisor or PHN team leader]

ANTEPARTUM

[Note: Do not fill out this page for New Postpartum clients]

EDC ____________ LMP ____________

Client entered prenatal care:

- ☐ During 1st trimester (before 13 weeks gestation)
- ☐ During 2nd trimester (between 13 weeks and 25 weeks)
- ☐ During 3rd trimester (between 26 weeks and delivery)
- ☐ No Prenatal Care

Fetal Demise (this pregnancy) ☐ Yes ☐ No Date: ____________
Previous Fetal Demise: ☐ Yes ☐ No
Previous LBW infant? ☐ Yes ☐ No

Client receiving Family Planning Services? ☐ Yes ☐ No

(Definition: receiving individualized family planning counseling and/or service with a medical provider or other health provider *during antepartum period.* The primary purpose is to provide services related to contraception, infertility, and/or sterilization.)

Referrals to WIC ☐ Yes ☐No

Was prenatal breastfeeding education provided? ☐ Yes ☐No

Assistance with Medi-Cal Provided during Antepartum? ☐ Yes ☐No

Does client have a primary care provider? ☐ Yes ☐No Date Updated:________
(During Antepartum period) ☐ Yes ☐No Date Updated:________
☐ Yes ☐No Date Updated:________

Does client have an OB/GYN Provider? ☐ Yes ☐No Date Updated:________
☐ Yes ☐No Date Updated:________
☐ Yes ☐No Date Updated:________

Was The Pregnant Women's Guide to Quit Smoking given? ☐ Yes ☐ No
Was the Pre-Treatment Book Used? ☐ Yes ☐ No
Was the client smoking during last 3 months of pregnancy? ☐ Yes ☐ No

Prenatal Care visits by OB provider or NP

Dates: **IMPORTANT [Enter all Prenatal Care Visits]

Other Medical Visits

ANTEPARTUM RISK FACTORS

[Note: Do not fill out this page for New Postpartum clients]

Key
0 – Negative (Risk Prevention Counseling)
X – Positive (Risk Reduction Counseling)
R – Referred for further assessment/treatment
TX – Already in treatment
RR - Refused Referral/Treatment
CR – Completed referral

Date Screened:							
RISK FACTOR							
Group B Strep or Bacterial Vaginosis							
HIV/AIDS							
Other STI/STDs							
Smoking							
Alcohol							
Illicit Drugs							
Depression							
Other Mental Health Problems							
Domestic Violence							
Homelessness							
Overweight & Obesity							
Underweight							
Hypertension							
Gestational Diabetes							
Peridontal Infection							
Asthma							
Family History of Breast Cancer							
SCREENING TOOLS USED							
Edinburgh (score)							

POSTPARTUM/WELL WOMAN

Did client report that she received **no prenatal care** prior to delivery? ☐ Yes ☐ No

Did Client have a Postpartum visit to a provider within 8 weeks of delivery? ☐ Yes ☐ No

Reported Problems: ____

____

____

____

____

____

Does client have a primary care provider? ☐ Yes ☐ No Date Updated:__________
(During Postpartum/Well Woman period) ☐ Yes ☐ No Date Updated:__________
☐ Yes ☐ No Date Updated:__________

Payor Source:
(Update if it changes During postpartum/ Well Woman)

☐ Medi-Cal (Full Scope) ☐ Healthy Families **Date Updated:**
☐ Medi-Cal Applied ☐ AIM __________
☐ Presumptive Eligibility ☐ Private Insurance __________
☐ Pregnancy Only Medi-Cal ☐ Self Pay __________
☐ Other____________________ __________

Client receiving Family Planning Services Postpartum? ☐ Yes ☐ No
Definition: receiving individualized family planning counseling and/or service with a medical provider or other health provider during postpartum period. The primary purpose is to provide services related to contraception, infertility, and/or sterilization.)

Assistance with Medi-Cal Provided during Postpartum? ☐ Yes ☐ No

POSTPARTUM RISK FACTORS

Key
0 – Negative (Risk Prevention Counseling)
X – Positive (Risk Reduction Counseling)
R – Referred for further assessment/treatment
TX – Already in treatment
RR – Refused Referral/Treatment
CR – Completed referral

Date Screened:							
RISK FACTOR							
HIV/AIDS							
Other STI/STDs							
Smoking							
Alcohol							
Illicit Drugs							
Depression							
Other Mental Health Problems							
Domestic Violence							
Homelessness							
Overweight & Obesity							
Underweight							
Hypertension							
Peridontal Infection							
Asthma							
Lack of Physical Activity							
Family History of Breast Cancer							
Cholesterol							
Fecal Occult Blood Test							
SCREENING TOOLS USED							
Edinburgh (score)							

INFANT

Infant ID (Avatar #) ___________ Infant DOB: ___________

Live Birth: ☐ Yes ☐ No Infant birth: ☐ Single ☐ Twin ☐ Multiple (triplets +)

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other

Gestational age at birth (in weeks): _______

Birth Weight (Lbs. & Oz) ____ lbs ____ oz Length in inches _________ in

Hospital stay of more than 48 hours: ☐ Yes ☐ No

Reason for increased hospital stay____

____

____

Number of days on Ventilator: ______ days

Reported problems: Check all that apply (Include those reported by mothers)

- ☐ Breech Delivery
- ☐ Elevated Bilirubin/Jaundice
- ☐ Low Apgar scores
- ☐ Fetal Distress
- ☐ Delivery Complications
- ☐ Hypoglycemia
- ☐ Positive Toxicity Screen
- ☐ Intrauterine Drug Exposure without tox positive
- ☐ Genetic Defect
- ☐ Congenital Defect
- ☐ Stillborn
- ☐ Respiratory Distress
- ☐ Other (Explain below)

____

Does infant have a primary care provider? ☐ Yes ☐No Date Updated:__________
☐ Yes ☐No Date Updated:__________
☐ Yes ☐No Date Updated:__________

INFANT (Continued)

Payor Source: (Infant)

- ☐ Medi-Cal (Full Scope)
- ☐ Medi-Cal Applied
- ☐ Presumptive Eligibility
- ☐ Pregnancy Only Medi-Cal
- ☐ Other ______________________
- ☐ Healthy Families
- ☐ AIM
- ☐ Private Insurance
- ☐ Self Pay

Date Updated:

____
____
____
____

Well Child (Exams by Pediatric Provider) (0 to 2 years):
Dates Only:

________	________	________	________	________	________
________	________	________	________	________	________
________	________	________	________	________	________

Immunizations:

Up to date at 2 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at 4 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at 6 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at 12 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at 15 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at 24 Months:	☐ Yes	☐ No	☐ Unknown	Date checked__________________
Up to date at Discharge:	☐ Yes	☐ No	☐ Unknown	Date checked__________________

Infant Mortality:

Date Infant Died: ______________

Was the infant's death determined to be SIDS? ☐ Yes ☐ No ☐ Unknown

INFANT/CHILD RISK FACTORS

Key
0 – Negative (Risk Prevention Counseling)
X – Positive (Risk Reduction Counseling)
R – Referred for further assessment/treatment
TX – Already in treatment
RR – Refused Referral/Treatment
CR – Completed referral

Date Screened:							
RISK FACTOR							
Prenatal Secondhand Smoke Exposure							
Mental Health Problems							
Family Violence/ Intentional Injury							
Homelessness							
Not Attaining Appropriate Growth							
Developmental Delays							
Asthma							
HIV/AIDS							
*Other Special Health Care Needs							
Failure to Thrive							
SCREENING TOOLS USED							
ASQ (score)							
ASQ-SE (score)							
Language Assessment							

***Special Health Care Needs Description:**____

BREASTFEEDING

Was Breastfeeding support/consultation provided to client: ☐ Yes ☐ No
If no, why not? ____________________

Was client still breastfeeding **EXCLUSIVELY**:

at hospital discharge?	☐ Yes	☐ No	☐ Never Started
14 days after delivery?	☐ Yes	☐ No	☐ N/A
at 2 months after delivery?	☐ Yes	☐ No	☐ N/A
at 6 months after delivery?	☐ Yes	☐ No	☐ N/A
Never breastfed exclusively	☐ Yes	☐ No	☐ N/A

Was client still breastfeeding:

at hospital discharge?	☐ Yes	☐ No	☐ Never Started
14 days after delivery?	☐ Yes	☐ No	☐ N/A
at 2 months after delivery?	☐ Yes	☐ No	☐ N/A
at 6 months after delivery?	☐ Yes	☐ No	☐ N/A
at 18 months after delivery?	☐ Yes	☐ No	☐ N/A
at 24 months after delivery?	☐ Yes	☐ No	☐ N/A

If client has stopped or never started breastfeeding, **why**? (Check all that apply below)

- ☐ Client decided she did not make enough milk
- ☐ Client decided the bottle easier/more convenient
- ☐ Client decided the baby preferred the bottle/nipple over breastfeeding
- ☐ Client complained breastfeeding was painful
- ☐ Client had to return to work/school
- ☐ Client did not have access to a breast pump
- ☐ Client had inadequate breast pump for frequent pumping
- ☐ Client's employer has not implemented Lactation Accommodation law to allow time or space to breastfeed
- ☐ A health professional said to stop breastfeeding
- ☐ A family member wanted client to stop breastfeeding
- ☐ Client stopped breastfeeding due to embarrassment or shame
- ☐ Client perceives breastfeeding to be a disincentive for obtaining formula from WIC
- ☐ Other____________________
- ☐ Unknown

REFERRALS/PSYCHO-SOCIAL
(This information needs to be collected for each Calendar Year)

Did client receive *direct* transportation services? ☐ Yes ☐ No Year:__________
(Includes transports and bus tokens)

Did client receive *direct* translation services? ☐ Yes ☐ No Year:__________

Did client receive *direct* childcare services? ☐ Yes ☐ No Year:__________

Was a referral made to MSW? ☐ Yes ☐ No Year:__________

Lack of Family Support (presence of isolation):

Extended family unable or unwilling to provide necessary psychosocial, emotional and/or physical support during the perinatal period. ☐ Yes ☐ No Year:__________

Referrals:

Jobs/Job Training (Job Skills, GED, ESL, GAIN Program) ☐ Yes ☐ No Year:________

Health Education Services:

Nutrition Education: ☐ Yes ☐ No Year__________

Childbirth Education: ☐ Yes ☐ No Year:__________

Parenting Education: ☐ Yes ☐ No Year:__________

Adolescent Education: ☐ Yes ☐ No Year:__________

(Applies only to clients 17 years of age and under who participated in any type of pregnancy prevention activities or adolescent education. If client is not under the age of 18 then do not answer.)

Number of referrals completed for health education services:__________ Year:__________
(referrals that the client completed for any type of health education class/service)

Daily Activity Report

Name:														**County Car #:**				
Position:							**Date:**							**Mileage (Start/End):**				
Time	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00	4:30
Program																		
Site																		
Client #																		
Status																		
Travel Time																		
Activity code																		
Telephone																		
Meeting																		
Training																		
Tracking																		
Office Work																		
Time Off																		
Services																		
Other																		
Explanations:																		

Program
AF= AFLP
B1= Babies First
BH= BIH
BF= Breastfeeding
CH= CCHLP
CM= CCM
CP= CPSP
FI= FIMR
HR= HIRI
IH= IHSS
IM= Immunization
LI= Liaison
MI= MIECHV
NF= NFP
O= Other
PE= PEI
PM= Perinatal MH
PR= PH Response
SA= SA
SI= SIDS

Site
CC= Childcare Center
C= Clinic
CA= Community Agency
CT= Community Center
CL= Community Clinic
CF= Correctional Facility
F= Family Planning
H= Home
HS= Hospital
OF= Office
O= Other
OR= Outreach
P= Provider
S= School
T= Treatment Facility

Activity
CC= Case Consult/SPHN/MSW
CH= Charting/Doc
C= Correspondence
CP= CPS Report
DE= Data Entry
DR= Discharge Rounds
FV= Field Visit
GR= Group
HV= Home Visit
M= Meeting
O= Other
OR= Outreach
PP= Preparation
PR= Presentation
R= Referral
RP= Report
RS= Research
SV= Site Visit
SS= Student Supervision
T= Telephone
TR= Training

Telephone code
A= Attempted
CP= Childcare Provider
C= Client
CA= Community Agency
CO= County Office
DC= Department Call Center
FM= Family Member
FO= Federal Office
F= Funder
H= Hospital
L= Law Enforcement
MP= Medical Provider
MK= Mom & Kids Hotline
O= Other
RS= Referral Source
S= School
SO= State Office

Meeting code
CC= Case Conference
CA= Community Agencies
C= County Departments
D= Division
F= Federal
O= Other
P= Provider
R= Rounds/DC Planning
S= Staff
ST= State
TF= Task Force
11= 1:1 Meeting

Status
C= Close
F= Follow Up
I= Initial
OP= Open
O= Other
S= Services

Training
CS= Community Sponsored
C= CPR
DS= Department Sponsored
D= Division
FS= Federally Sponsored
H= Harassment
HI= HIPAA
N= New Employees
O= Other
R= Requested CE
SS= State Sponsored

Attempt code
CP= Completed
NF= Not Found
NH= Not Home
O= Other
R= Refused

Daily Activity Report

Services
AP= Antepartum
IN= Infant
O= Other
PP= Postpartum
P= Preschool
T= Toddler
WW= Well Woman

Tracking
DV= Domestic Violence
E= Education/Employment
GD= Growth & Development
MH= Mental Health
N= Nutrition
PA= Physical Abuse/Neglect
PC= Pre/Contra/Interconception
R= Referral
S= Screening
SA= Substance Abuse

Office Work
C= Copying
DA= Daily Activity Report
D= Desk In-box
E= Email- Read & Reply
N= Nurse of the Day
O= Other
P= Phone Coverage
PR= Processing Referral
TS= Time Sheet/Time Study
T= Training/Travel request

Time Off
AL= Annual Leave
B= Break
C= Comp Time
CE= Continuing Education
FL= Flex Time
H= Holiday
O= Other
S= Sick leave

MCAH REQUEST FOR MEDICAL SOCIAL WORKER SERVICES

Today's Date:		Date Opened to Service:	
PHN/HEA:		Prog:	Phone:
Client Name:		DOB:	MR#:
Street:		Apt:	CT:
City:		Zip Code:	
Phone No:	Ethnicity:	Language:	
MediCal or SSN:			
Pregnant:	Yes☐	EDC:	
	No☐	Pregnancy Outcome:	
		Date of Delivery:	
Service Requested:	Consult☐	Assessment☐	Assistance with Linkage to services ☐
Client Agrees to Assistance :	Yes☐	No☐	Next PHN/HEA HV:
Presenting Problem:			
Client Strengths:			

Identified Problems (Check all that apply):

☐	Previous MH Treatment	☐	Domestic Violence	☐	Substance Abuse/Self
☐	Child Behavior	☐	Bonding/Attachment	☐	Substance Abuse/Other
☐	Suicidal	☐	Sexual Abuse/Trauma	☐	Medical Problems
☐	Abused as Child	☐	Hx of CPS Intervention	☐	School Problems
☐	Anxiety	☐	Depression	☐	Legal Difficulties
☐	Psychotic Symptoms	☐	EPDST Score	☐	Partner Relationship Problems
☐	Anger/Conflict Management	☐	EPDST attached	☐	Conflict with Parents

Other Family Members Who Live in the Home

Name	Age/DOB	Relationship

☒ **Reviewed with PHN/SPHN** PHN signature/date________________________

County of Fresno

DEPARTMENT OF PUBLIC HEALTH
EDWARD L. MORENO, M.D., M.P.H.
DIRECTOR-HEALTH OFFICER

Department of Public Health
Perinatal Program
P.O. Box 11867
Fresno, California 93775
(559) 600-1021

Dear

The Department of Public Health, has received a referral to work with you from the Department of Behavioral Health.

I have made several attempts to contact you, but have been unsuccessful. I would very much like to meet with you and discuss the purpose of the program and how I can be of help to you.

Please call me at (559) 600-1021 within the next two weeks. I will place your referral in our closed file if I do not hear from you.

Sincerely,

Public Health Nurse

County of Fresno
DEPARTMENT OF PUBLIC HEALTH
EDWARD L. MORENO, M.D., M.P.H.
DIRECTOR-HEALTH OFFICER

Referral Reply Response

This is to inform you that we received your referral for

Client Name:____________________________ (DOB):______________

☐ Has received information and resources

☐ Has been unresponsive to attempted contacts, and has been closed for further follow-up

☐ Other: ____

If you have any questions, please contact______________________, PHN at 445-3515.

Thank you,

____________________, Public Health Nurse
Public Health Nursing/MCAH

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY
TIMESTUDY SURVEY FOR FFP PROGRAM CLAIMING

DEPARTMENT OF HEALTH SERVICES

Period (Mo/Yr): November 2010

EMPLOYEE NAME	POSITION/TIMESHEET #	PERSONNEL CLASSIFICATION	AGENCY/ENTITY	UNIT NAME
Kelley Kathleen	26	Public Health Nurse II	Fresno County-Public Hlth.	MCAH

LOCATION

Program Coding Scheme
- A - 1700 - BIH
- B - 1706 - MCH
- C - 1710 - West Fresno Nursing
- D - 1719 - Nurse Family Partnership
- E - 1677 - Child Care Health Linkages
- F - 1670 - High Risk Infant Program
- G - Other (1748, 1500, 1501, 5600, etc.)
- H -

Date	CC #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hrs
1 Outreach	1700																																
	1706																																
2 SPMP Admin. Medical Case Management	1700																																
	1706																																
3 SPMP Intra/Interagency Coord., Collab. and Admin.	1700																																
	1706																																
4 NON-SPMP Intra/Interagency Coord., Collab. and Admin.	1700																																
	1706																																
5 Program Specific Administration	1700																																
	1706																																
6 SPMP Training	1700																																
	1706																																
7 NON-SPMP Training	1700																																
	1706																																
8 SPMP Program Planning and Policy Development	1700																																
	1706																																
9 Quality Management by Skilled Med. Personnel	1700																																
	1706																																
10 Non-Program Specific General Administration	1700																																
	1706																																
11 Other Activities	1700																																
	1706																																
	Other																																
12 Paid Time Off	1700																																
	1706																																
	Other																																
Daily Total Hrs	1700																																
	1706																																
	Other																																

Enhanced (Codes 2+3+6+8+9)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog.C ____ Prog. G ____
Prog. D ____ Prog. H ____

Paid Time Off (Code 12)
Total- ____

Non-Enhanced (Codes 1+4+5+7)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog.C ____ Prog. G ____
Prog. D ____ Prog. H ____

Non-Prog Specific Administration (Code 10)
Total- ____

Non-Claimable (Code 11)

Prog. A ____ Prog. E ____
Prog. B ____ Prog. F ____
Prog.C ____ Prog. G ____
Prog. D ____ Prog. H ____

EMPLOYEE I hereby certify that this is a true and accurate report of my time and that the functions were performed as shown above

Employee's Signature ____ Date ____

SUPERVISOR. I hereby certify that the employee's time records have been examined and that, to the best of my knowledge and belief, this time record is valid and correct and the functions were performed as shown above.

Supervisor's Signature ____ Date ____

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Reporting Year________

Table 1

Pregnant Women Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Pregnant Women (All Ages)							
10-14							
15-19							
20-24							
25-34							
35-44							
45 +							

Table 2

Infants, Children and Youth Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Infants <1							
Children and Youth 1 to 25 years							
12-24 months							
25 months-4 years							
5-9							
10-14							
15-19							
20-24							

Table 3

CSHCN Infants, Children and Youth Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Infants <1 yr							
Children and Youth 1 to 25 years							
12-24 months							
25 months-4 years							
5-9							
10-14							

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

15-19		
20-24		

Table 4

Women Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	**Unknown % (g)**
Women 25+							
25-29							
30-34							
35-44							
45-54							
55-64							
65+							

Table 5

Other	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	**Unknown % (g)**
Men 25+							

TOTAL SERVED: ______________

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

FORM 5 WORKSHEET
BREAKDOWN OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Program Participants

For Projects Providing Direct Health Care, Enabling or Population-based Services

Table 1		
Pregnant Women Served	**(a) Number Served**	**(b) Program Participants**
Pregnant Women (All Ages)		
10-14		
15-19		
20-24		
25-34		
35-44		
45 +		
Table 2		
Infants, Children and Youth Served	**(a) Number Served**	**(b) Program Participants**
Infants < 1 year		
Children and Youth 1 to 25 years		
12-24 months		
25 months-4 years		
5-9		
10-14		
15-19		
20-24		
Table 3		
CSHCN Infants, Children and Youth Served	**(a) Number Served**	**(b) Program Participants**
Infants < 1 year		
Children and Youth 1 to 25 years		
12-24 months		
25 months-4 year		
5-9		
10-14		
15-19		
20-24		
Table 4		
Women Served	**(a) Number Served**	**(b) Program Participants**
Women 25 +		
25-29		
30-34		
35-44		
45-54		
55-64		
65 +		
Table 5		
Other	**(a) Number Served**	**(b) Program Participants**
Men (25+)		
Other		

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
a. Number of Pregnant Women												
Under age 15												
Aged 15-17												
Aged 18-19												
Aged 20-24												
Aged 25-34												
Aged 35-44												
45+												
Age Unknown												
Total Number of Pregnant Women												
b. Number of Pregnant Women with Incomes:												
Below 100 Percent of the FPL												
Between 100-185 Percent of the FPL												
Income Unknown												

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET
REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
Total Number of Pregnant Women with Incomes												
c. Number of Pregnant Participants by Entry into Prenatal Care:												
During First Trimester												
During Second Trimester												
During Third Trimester												
Receiving No Prenatal Care												
Total Number of Pregnant Participants by Entry into Prenatal Care												
Trimester Unknown												
Total Number of Pregnant Participants by Entry into Prenatal Care including Trimester Unknown												
d. Adequate Prenatal Care												

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET
REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
Total Number of Pregnant Participants Receiving Adequate Prenatal Care (Kotelchuck[1],or similar index)												
Level of Adequate Prenatal Care Unknown												
Total number of pregnant participants Receiving Adequate Prenatal Care including unknown Adequacy of Care												
e. Live Singleton Births to Participants												
Number of live singleton births greater than or equal to 2500 grams to participants												
Number of live singleton births between 2499 grams and 1500 grams to participants												

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET
REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
Number of live singleton births less than 1499 grams to participants												
Number of live singleton births weight unknown												
Total Number of Live Singleton Births to Participants												
Total Number of Live Births to Participants including Multiple Births												
Total Number of deaths of program participants attributed to maternal conditions and complications of pregnancy and childbirth during pregnancy, childbirth and up to 42 days after delivery.												
Total Number of deaths of program participants attributed to maternal conditions and complications of pregnancy and from 43 days to one year after												

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	Hispanic or Latino	Not Hispanic or Latino	Unrecorded	TOTAL	America Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race	Unrecorded	Total
delivery.												
f. Number of Female Participants in Interconceptional Care/Women's Health Activities												
Under age 15												
Aged 15-17												
Aged 18-19												
Aged 20-23												
Aged 24-34												
Aged 35-44												
Aged 45 +												
Age Unknown												

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET
REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
Total Number of Female Participants in Interconceptional Care/Women's Health Activities												
g. Infant/Child Health Participants												
Number of Infant Participants Aged 0 to 11 months												
Number of Child Participants aged 12 to 23 months												
Number of Infant/Child Participants Age Unknown												
Total Number of Infant/Child Health Participants												
h. Male Support Services Participants												
Number of Male Participants 17 years and under												
Number of Male Participants 18 years and older												

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET
REVISED- Section A. Characteristics of Program Participants

	ETHNICITY				RACE							
Characteristics of Program Participants	**Hispanic or Latino**	**Not Hispanie or Latino**	**Unrecorded**	**TOTAL**	**America Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**More Than One Race**	**Unrecorded**	**Total**
Number of Male Participants Age Unknown												
Total Number of Male Support Services Participants												

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

	B. RISK REDUCTION/PREVENTION SERVICES (For Program Participants)			
RISK FACTORS	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
a. PRENATAL PROGRAM PARTICIPANTS				
Group B Strep or Bacterial Vaginosis				
HIV/AIDS				
Other STDs				
Smoking				
Alcohol				
Illicit Drugs				
Depression				
Other Mental Health Problem				
Domestic Violence				
Homelessness				
Overweight & Obesity				
Underweight				
Hypertension				
Gestational Diabetes				
Family History of Breast Cancer				
Asthma				
Peridontal Infection				

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

C. HEALTHY START MAJOR SERVICE TABLE

a. DIRECT HEALTH CARE SERVICES

Prenatal Clinic Visits:	Number of Medical Visits by All Prenatal Participants	
Postpartum Clinic Visits	Number of Medical Visits by All Postpartum Participants	
Well Baby/ Pediatric Clinic Visits	Number of Any Provider Visits by All Infant/Child Participants	
Adolescent Health Services	Number of any Provider Visits by Participants age 17 and under	
Family Planning	Number of Participants Receiving Family Planning Services	
Women's Health	Number of Participants Receiving Women's Health Services	

b. ENABLING SERVICES

Total Number of Families Served	
Number of Families in the Prenatal Period Assisted by **Case Management**	
Number of Families in the Interconceptional Period Assisted by **Case Management**	
Number of Families in the Prenatal Period Assisted by **Outreach**	
Number of Families in the Interconceptional Period Assisted by **Outreach**	

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

Number of Families in the Prenatal Period Receiving **Home Visiting**

Number of Families in the Interconceptional Period Receiving **Home Visiting**

Number of Participants Age 17 and Under who participated in **Adolescent Pregnancy Prevention Activities**

Number of Families who participated in **Pregnancy/Childbirth Education Activities**

Number of Families who participated in **Parenting Skill Building/Education**

Number of Participants in **Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs**

Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans

Number of Families Who Receive **Translation Services**

Number of Families Receiving **Child Care Services**

Number of Participants Who Received **Breastfeeding Education , Counseling and Support**

Number of Participants Who Received **Nutrition Education and Counseling Services** including WIC Services

Number of Participants in

OMB # 0915-0298
EXPIRATION DATE: October 31, 2012

Male Support Services: [ ]

Number of Participants Referred for **Housing Assistance** [ ]

Total Participants assisted with **Jobs/Jobs Training** [ ]

Total Participants served in **Prison/Jail Initiatives** [ ]

c. POPULATION

Number Of **Immunizations** Provided [ ]

Public Information/Education: Number of Individuals Reached [ ]

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained [ ]

Provider Training Number of Individual Providers Trained [ ]