Steps Ahead

CARE COORDINATOR ENCOUNTERS REPORT

Recipient's Name: _____ **SS#:** _____ **Medicaid#:** _____

EDC: _____ **DHCP:** _____ **Risk Status** ☐ **High** ☐ **Low** **Gravida** _____ **Para** _____

	Initial Encounter	Subsequent Encounter	Subsequent Encounter
Date of Encounter			
Type of Encounter	☐ Face to Face	☐ Face to Face ☐ Telephone	☐ Face to Face ☐ Telephone
GA at Encounter	_____wks _____days	_____wks _____days	_____wks _____days
Keeping Prenatal Appts	☐ Yes ☐ No ☐ scheduled	☐ Yes ☐ No Reason:_____	☐ Yes ☐ No Reason:_____
Medicaid Status	☐ Approved ☐ Plan 1st ☐ Pending ☐ Denied	☐ Approved ☐ Plan 1st ☐ Pending ☐ Denied	☐ Approved ☐ Plan 1st ☐ Pending ☐ Denied
If Medicaid Pending or Denied	☐ Application ☐ Form 295 ☐ Reapplication _____	☐ Application ☐ Form 295 ☐ Reapplication _____	☐ Application ☐ Form 295 ☐ Reapplication _____
Discussed or Attended Prenatal Classes	☐ Interested ☐ Enrolled ☐ Undecided	☐ Yes ☐ No	☐ Yes ☐ No
Birth Control Method Chosen / Plan First	☐ Yes ☐ No ☐ Handout given	☐ Pills ☐ Depo ☐ IUD ☐ Implant ☐ BTL ☐ None	☐ Pills ☐ Depo ☐ IUD ☐ Implant ☐ BTL ☐ None
Is patient on WIC?	☐ Yes ☐ No ☐ Form given	☐ Yes ☐ No	☐ Yes ☐ No
List Pediatric Provider	List Given & Discussed ☐ Yes ☐ No	Dr. name _____ ☐ Undecided	Dr. name _____ ☐ Undecided
Tobacco Use	☐ Yes ☐ No ☐ Quit	☐ Yes ☐ No ☐ Quit	☐ Yes ☐ No ☐ Quit
Alcohol/Drugs	☐ Yes ☐ No ☐ Hx	☐ Yes ☐ No ☐ Hx	☐ Yes ☐ No ☐ Hx
Drug Treatment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mental Health Issues	☐ Hx ☐ No ☐ Yes _____	☐ Hx ☐ No ☐ Yes _____	☐ Hx ☐ No ☐ Yes _____
Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Transportation	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate
Financial Support	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate
Housing Adequate	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate	☐ Adequate ☐ Inadequate
Support System	☐ Good ☐ Fair ☐ Poor	☐ Good ☐ Fair ☐ Poor	☐ Good ☐ Fair ☐ Poor
Family concerns	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No
Pregnancy Issues	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No
Prenatal Vitamins	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Baby Needs	Gathering: ☐ Yes ☐ No	Gathering: ☐ Yes ☐ No	Has: ☐ car seat ☐ crib
SIDS/Back to Sleep	Discussed/handout ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No
Breast/Bottle Feeding	☐ Breast ☐ Handout ☐ Bottle	☐ Breast ☐ Bottle	☐ Breast ☐ Bottle
Shaken Baby Syndrome	Discussed/handout ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No
Smile Alabama	Discussed/handout ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No
MOD Last Weeks Count	Discussed/handout ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No	Discussed: ☐ Yes ☐ No
Care Coordinator Name			

Notes: _____

PSYCHOSOCIAL ASSESSMENT WORKSHEET

Circle "Y" or "N" as appropriate

Married ☐ Single ☐

Social Supports
N Y Good relationship with partner
Y N Family violence
N Y Good support system
N Y Good relationship with relatives

Community Supports
N Y Transportation adequate
Y N Legal assistance needed
N Y Attends/member of church
Y N Needs referral for community service

Shelter/Nutrition
Y N Homeless or soon to be evicted
N Y Dwelling safe and sanitary
N Y Utilities connected
Y N Lives alone
N Y Adequate food
N Y Home telephone/message telephone

Economic Status
N Y Employed
N Y Adequate income
N Y Adequate budgeting
Y N Public benefits needed

Educational Needs
Y N Limited or incomplete education
Y N Language or literacy barrier
Y N History of special education
N Y School age children attending school

Emotional/Physical Health
Y N Mental health problems
Y N Drug, alcohol use/abuse
N Y Good physical health
Y N Tobacco use

Pregnancy Issues
Y N Current pregnancy fears/anxiety
Y N Incest or rape vistim
N Y Satisfactory family planning
N Y Parenting experience
N Y Child care plan
Y N Considering alternatives to pregnancy
N Y Understands importance of prenatal care
Y N Problems with previous pregnancies
Y N Late registrant for care
Y N Adolescent mother

HIV & Aids Issues
Y N Needs referral to doctor/clinic
Y N HIV Symptoms
Y N Other HIV & family members/partner
N Y Understands/Practices safer sex
N Y Medicaid/Health insurance
N Y Physical/Emotional support available
Y N Needs financial assistance with medications

Child Health Issues
Y N Needs referral to doctor/specialty clinic
N Y Age-appropriate development

FOB Name _____

FOB not involved? Paternity Yes ☐ No ☐

Reports domestic violence ☐ Denies ☐

Family: Supportive ☐ Non-supportive ☐

☐ Has own car ☐ Family/FOB will provide transportation

☐ WIC ☐ Food Stamps ☐ Kid One ☐ Net

Lives in: ☐ Apartment ☐ House ☐ Mobile home

Lives with: ☐ Parents ☐ FOB ☐ Husband ☐ Other

☐ Cell phone ☐ Home phone

☐ Works full time ☐ Part time ☐ Unemployed

Provide financial assistance: ☐ Husband ☐ FOB ☐ Parents

☐ HS grad ☐ GED ☐ College Last grade completed ____

Counseled on smoking cessation Y N quitline handout

Initiated prenatal care at _____ weeks EGA

Pregnancies _____ # children _____

Open DHR case: ☐ Yes ☐ No Custody issues: ☐ Yes ☐ No

☐ Daycare ☐ Stay at home mom ☐ other

Hx of STDs: ☐ Yes ☐ No