OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
OUTCOME MEASURES AT CASE CLOSURE
PRENATAL

Client Name: Last First MI

Infant 1 ☐; Infant 2 ☐; Infant 3 ☐; Infant 4 ☐ Did client fulfill service care plan goals? ☐ Yes ☐ No

HEALTH CARE

Does client have a medical home (i.e. primary care physician)? ☐ Yes ☐ No
Does client have a dental home? ☐ Yes ☐ No
How often does client go to dental appointments (check one)? ☐ Every 6 months ☐ Every year ☐ Less than annually ☐ Never
Did client receive a Tdap vaccine during this pregnancy? ☐ Yes ☐ No
Did client receive a flu vaccine during this pregnancy? ☐ Yes ☐ No
Was education on contraception and spacing between children provided to the client? ☐ Yes ☐ No
Does client currently use some form of contraception (check one)? ☐ Yes ☐ No ☐ Still pregnant ☐ Prefer not to answer
If yes, select option (check all that apply):
☐ IUD ☐ Implant ☐ Birth Control Pill ☐ Vaginal Ring ☐ Shot ☐ Patch ☐ Male condom ☐ Diaphragm
☐ Natural family planning ☐ Tubal Ligation ☐ Other, please specify: _____
If no, was the client referred to the Family Planning Program? ☐ Yes ☐ No
If client is still pregnant, how many weeks pregnant? _____ (weeks)
In what month was client's initial prenatal visit? Month # _____ ☐ None
How many prenatal appointments has the client attended? _____ appointments
Client used supplements during pregnancy (check all that apply)? Frequency of supplement use (check one):
☐ Folic acid ☐ Prenatal/Multivitamins
☐ 2 or fewer times per week ☐ 3 or 4 times per week
☐ 5 or more times per week ☐ Irregularly

High-risk pregnancy? ☐ Yes ☐ No
Was this birth a: ☐ Singleton birth ☐ Multiple (#): ____
If a multiple birth, did this pregnancy also result in (check one): ☐ Miscarriage (> 20 weeks) ☐ Stillborn (< 20 weeks) ☐ Live birth

SUBSTANCE USE

During pregnancy, did client drink alcohol? ☐ Yes ☐ No
If yes, how many alcoholic drinks did she have in an average week (check one)? ☐ Less than 1 ☐ 1-3 ☐ 4-7 ☐ 8-13 ☐ 14 +
During pregnancy, did client use or was client exposed to any substances? ☐ Yes ☐ No
If yes, what substance(s)? (check all that apply)
☐ Stimulants (cocaine, methamphetamine) ☐ Depressants (barbiturate, benzodiazepine) ☐ Hallucinogens (ecstasy, LSD, ketamine) ☐ Opioids (hydrocodone, codeine, oxycodone, morphine, heroin) ☐ Marijuana ☐ Caffeine ☐ Mercury ☐ Pesticides
☐ Nicotine (tobacco products, vape) ☐ Medication Assisted Treatment (Suboxone, Methadone, Vivitrol, etc.)
Is client currently in treatment for substance use? ☐ Yes ☐ No
If yes, what type of treatment (check all that apply)?
☐ Individual/Group Counseling ☐ Inpatient/Residential Treatment ☐ Medication Assisted Treatment
☐ Recovery Support Services ☐ Other, please specify: _____
Does anyone in the client's household (partner, parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)? ☐ Yes ☐ No
If yes, who and what substances: _____
If client used tobacco products at enrollment, did client (check one): ☐ Reduce use ☐ Quit use ☐ Neither
If client quit, did client remain tobacco free after delivery? ☐ Yes ☐ No
Did client begin using tobacco products during enrollment? ☐ Yes ☐ No

LABOR AND DELIVERY (IF DELIVERED)

Delivery Date: _____/_____/_____ Gestational Age: _____ (weeks)
Infant weight: _____ pounds _____ ounces Infant length: _____ inches
Delivery type (check one): ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section ☐ VBAC
At what hospital/birthing center did client deliver? _____
Were there any maternal complications during labor and delivery? ☐ Yes ☐ No
If yes, list: _____
If yes, did client deliver at a tertiary care center (e.g. a specialty hospital unit)? ☐ Yes ☐ No
Any birth defects present? ☐ Yes ☐ No
Was a NICU stay required? ☐ Yes ☐ No

If yes, number of days: _____

Was the infant exposed to substances during pregnancy (excluding caffeine, mercury, pesticides)? ☐ Yes ☐ No

Was the infant diagnosed with Neonatal Abstinence Syndrome? ☐ Yes ☐ No

BREASTFEEDING (IF DELIVERED)

Has the infant ever breastfed (including breastmilk supplemented with formula)? ☐ Yes ☐ No

Was the infant exclusively breastfed? ☐ Yes ☐ No

If yes, how long was the infant exclusively breastfed? ___ months

If no, was infant exclusively fed formula? ☐ Yes ☐ No

If eating solid food, at what age did infant start (includes cereal mixed in bottle; check one)? ☐ 0-3 months ☐ 4-6 months ☐ 7-12 months

Does infant have difficulty feeding: from bottle? ☐ Yes ☐ No

from breast? ☐ Yes ☐ No

If mother was advised not to breastfeed, reason: ☐ Medical reasons ☐ Substance use

If breastfeeding stopped, what were the reasons (check all that apply):

- ☐ Infant had difficulty latching or nursing
- ☐ Breast milk alone did not satisfy the baby
- ☐ Infant was not gaining enough weight
- ☐ Mother's nipples got sore, cracked or bleeding
- ☐ It was too hard, painful or too time consuming
- ☐ Infant was jaundiced
- ☐ Substance use
- ☐ Other: _____
- ☐ Mother was not producing enough milk/her milk dried up
- ☐ Mother had too many other household duties
- ☐ Mother felt it was the right time to stop breastfeeding
- ☐ Mother became sick and had to stop for medical reasons
- ☐ Mother went back to work or school
- ☐ Infant was living with another caretaker not mother
- ☐ Discouragement from friends/family

POSTPARTUM DEPRESSION (IF DELIVERED)

Did client keep postpartum appointment? ☐ Yes ☐ No

If no, is client scheduled for postpartum appointment? ☐ Yes ☐ No

Is the client receiving treatment for postpartum depression? ☐ Yes ☐ No

DCC USE ONLY

MEDICAL CONDITIONS

Did client have any of the following medical condition during her pregnancy (check all that apply)? ☐ Yes ☐ No

☐ Gestational Diabetes ☐ Pregnancy Induced Hypertension ☐ Urinary Tract Infections ☐ Vitamin/Iron Deficiencies

☐ Vaginal Bleeding ☐ STIs ☐ Preeclampsia ☐ Other, specify: _____

If yes, did client receive treatment for this condition(s) while pregnant? ☐ Yes ☐ No

Was education provided to client on medical conditions? ☐ Yes ☐ No

How much weight did the client gain during her pregnancy? ☐ 0-20lbs ☐ 21-40lbs ☐ 41-60lbs ☐ 61-100lbs ☐ 101lbs +

DCC NOTES

_____

_____

_____

DCC Signature:_____ **Service Date:** _____

Region: _____ **Agency:** _____ **County:** _____

Sign, then copy both sides of each sheet; original to DCC Agency and copy to RCC.