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

Name: Last First MI
SSN _____ - _____ - _____ Birthdate (mm/dd/yyyy) _____/_____/_____
Infant 1 ☐; Infant 2 ☐; Infant 3 ☐; Infant 4 ☐
Did client fulfill all service care plan goals? ☐ Yes ☐ No

PHYSIOLOGY OF LABOR AND DELIVERY
Delivery Date: _____/_____/_____
Were there any maternal complications during labor and delivery? ☐ Yes ☐ No
List: _____.
If yes, did patient deliver at a tertiary care center? ☐ Yes ☐ No
☐ Vaginal ☐ C-Section ☐ VBAC
Gestational Age_____(weeks)
Baby's weight and length at birth (specify unit): weight: _____ length: _____
Any birth defects present? ☐ Yes ☐ No
Was a NICU stay required? ☐ Yes ☐ No
If yes, number of days_____
☐ Infant Death ☐ Stillbirth
What was the age of infant at time of death?
☐ 0-24 hours ☐ 2 days-2 weeks ☐ 3 weeks-4 weeks
☐ 5 weeks-6 weeks ☐ 7 weeks-8 weeks
Reason for death:
☐ Genetic disorder ☐ Accident ☐ Drugs ☐ Alcohol ☐ SIDS/SUIDS
☐ Head trauma ☐ Unknown
☐ Other (state reason) _____.

MEDICAL CONDITIONS
Did client have any of the following medical condition during her pregnancy? ☐ Yes ☐ No
☐ Gestational Diabetes ☐ Pregnancy Induced Hypertension ☐ Urinary Tract Infections
☐ Vitamin/Iron Deficiencies ☐ Vaginal Bleeding ☐ STDs
☐ Preeclampsia ☐ Other
If yes, did client receive treatment? ☐ Yes ☐ No
Education provided on medical conditions? ☐ Yes ☐ No
How much weight did the client gain during her pregnancy?
☐ 0-20lbs ☐ 21-40lbs ☐ 41-60lbs ☐ 61-100lbs ☐ greater than 100lbs

POSTPARTUM DEPRESSON
Did client keep postpartum appointment? ☐ Yes ☐ No
If no, is client scheduled for postpartum appointment? ☐ Yes ☐ No
Was the Edinburgh Postnatal Depression Scale administered to client? ☐ Yes ☐ No
Is the client receiving treatment for postpartum depression? ☐ Yes ☐ No

CONTRACEPTIVE CARE
Did mother begin a method of birth control after delivery? ☐ Yes ☐ No
If no, was the mother referred to the Family Planning Program? ☐ Yes ☐ No
Was education on contraception and spacing between children provided to the client? ☐ Yes ☐ No

SUBSTANCE ABUSE
Was there maternal substance use during pregnancy? ☐ Yes ☐ No
Maternal substance use treatment? ☐ Yes ☐ No
If yes, what substance(s): (check all that apply)
☐ Alcohol ☐ Marijuana ☐ Stimulants (cocaine, methamphetamines) ☐ Hallucinogens (ecstasy)
☐ Opioids (hydrocodone, buprenorphine, oxycodone, morphine, heroin) ☐ Other Drugs (inhalants, ketamine)
Is infant drug affected/drug exposed? ☐ Yes ☐ No
Infant received neonatal abstinence syndrome treatment? ☐ Yes ☐ No

TOBACCO/NICOTINE USE

☐ Never smoked ☐ Quit before or after becoming pregnant ☐ Current Smoker

Client participated in SCRIPT? ☐ Yes ☐ No

Tobacco/Nicotine used by current user (check all that apply):

☐ Cigarettes ☐ Smokeless tobacco ☐ E-Cigarettes/Vaping

Client has reduced the number of daily usage? ☐ Yes ☐ No

If client has reduced, what is client's daily usage:

☐ Less than 1 ☐ 1-5 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ more than 20

Client has remained tobacco/nicotine reduced through delivery? ☐ Yes ☐ No

If client quit while in RFTS, what did client use: ☐ SCRIPT ☐ WV Quitline ☐ Other (specify below)

If other, please specify: _____.

Was there exposure to environmental tobacco smoke at closure? ☐ Yes ☐ No

If so where: ☐ Home ☐ Car ☐ Other, explain. _____.

CO level at time of closure (ppm): _____ ☐ Refused ☐ Equipment problem

ORAL HEALTH

When was the last time the client visit the dentist?

☐ One year or less than one year ☐ More than one year ☐ Never

Did client receive oral/dental care during RFTS? ☐ Yes ☐ No

What were the reasons the client did not get the dental care she needed?

☐ Client did not think anything serious was wrong/expected dental problems to go away

☐ Could not afford the cost ☐ Was not recommended ☐ Medical provider advised against it

☐ No transportation ☐ Fear of dentist ☐ Other _____

Does client have a dental home? ☐ Yes ☐ No

FEEDING/BREASTFEEDING

Did client exclusively breastfeed (breastmilk only) at (choose all that apply): ☐ Yes ☐ No

☐ Hospital discharge ☐ Case closure

Is client receiving breastfeeding support? ☐ Yes ☐ No

If yes, from: _____

If no, did client try to breastfeed? ☐ Yes ☐ No

What were the client's reasons for not breastfeeding?

☐ Sick/taking medication ☐ Other children required care ☐ Tried but too hard

☐ Too many household duties ☐ Did not like breastfeeding ☐ Did not want to

☐ Went back to school/work ☐ Discouragement from family/friends

☐ Other: _____.

Does client understand the benefits of exclusively breastfeeding? ☐ Yes ☐ No

SAFETY/HEALTH

Does baby have a primary care provider? ☐ Yes ☐ No

Did someone discuss infant safe sleep practices with the caretaker and give them materials prior to leaving the hospital? ☐ Yes ☐ No

Was safe sleep education provided to the caretaker by RFTS? ☐ Yes ☐ No

Did someone discuss the Period of Purple Crying educational materials with caregiver and give them materials about coping with crying prior to leaving the hospital? ☐ Yes ☐ No

If RFTS provided Period of Purple Crying education, was the caregiver engaged in face-to-face discussion (including Q&A) about the education materials? ☐ Yes ☐ No

Does baby sleep on his/her back? ☐ Yes ☐ No

Does caretaker use a child safety seat to transport infant? ☐ Yes ☐ No

Is caretaker aware of current child safety seat laws? ☐ Yes ☐ No

Flu shot received: ☐ Before enrolling in RFTS ☐ After enrolling in RFTS ☐ None

If none, why: ☐ Refused ☐ Not aware ☐ Other (specify):_____.

Did baby receive Newborn Metabolic Screening (heel stick) during RFTS? ☐ Yes ☐ No

Did baby receive pulse oximetry screen during RFTS? ☐ Yes ☐ No

Did mother receive Tdap vaccine during RFTS? ☐ N/A ☐ Yes ☐ No

Did mother receive Tdap vaccine between 27 and 36 weeks of gestation? ☐ Unknown ☐ Yes ☐ No

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

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

Both sides copied with original sent to DCC Agency and copy to RCC.