WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
Office of Maternal, Child and Family Health

OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
CLIENT TRACKING FORM

Right From the Start
Healthy Beginnings for You and Your Baby

DCC Name: _____ **DCC Agency**: _____ **Region**: _____
Service Date: ___ /___ /_____ **Prep Time**: ___ hr ___ min **Travel**: ___ hr ___ min ____ miles **Next visit scheduled?** ☐ Yes ☐ No
Visit Location: ☐ Home ☐ Office ☐ Virtual ☐ Phone ☐ Other _____ **Face-to-face visit?** ☐ Yes ☐ No

Client Name: _____
SSN: _____ **DOB**: ____ /____ /_____
Gender: ☐ F ☐ M **County of Residence**: _____
Address: _____
City: _____ **State**: _____ **Zip code**: _____
Phone Number: _____
Last Medical Visit: ____ /____ /_____ ☐ **Change in Contact Info**
Next Medical Visit: ____ /____ /_____
Medical Home: _____ ☐ N/A

PRENATAL
Estimated Due Date: ___ /____ /_____ ☐ **Updated**
OB/GYN Provider: _____
Birth Facility: _____

POST
Actual Delivery Date: ____ /____ /_____
Contraceptive Care Plan: ☐ Yes ☐ No
Postpartum Medical Visit: ☐ Yes ☐ No

INFANT
Guardian Name: _____
Guardian SSN: _____
Relationship: ☐ Mother ☐ Father ☐ Grandparent
☐ Foster Parent ☐ Other _____
Weight: ____ lbs ____ oz **Height**: _____ inches

CARED BY
Is the baby currently in a NICU? ☐Yes ☐ No
Is the baby currently in the care of CPS? ☐Yes ☐ No
If yes, is there a Plan of Safe Care in place? ☐Yes ☐ No

SMOKING CESSATION
☐ Non-smoker ☐ Cigarettes ☐ E-cigarettes/Vaping
☐ Other tobacco product _____
CO Value____ PPM ☐ Refused ☐ Phone/Virtual
☐ Equipment Problem ☐ See Progress Note
Currently smoke the following amount of cigarettes per day: ☐Quit ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ > 1 pack ☐ > 2 packs

TOPICS & DISCUSSION

	D	R		D	R
Nutrition	☐	☐	Acute Care for Infant	☐	☐
Advocacy	☐	☐	Child Abuse Prevention	☐	☐
Financial	☐	☐	Developmental Progress	☐	☐
Environment	☐	☐	Domestic Violence	☐	☐
Oral Health	☐	☐	Depression Screening	☐	☐
Substance Use	☐	☐	Transportation	☐	☐
Well Child Care	☐	☐	Care Coordination	☐	☐
SBIRT	☐	☐	Curriculum	☐	☐
Family Planning	☐	☐	Safe Sleep	☐	☐

D – Discussed R – Referral Made

Insured by ☐ Medicaid ☐ MCO _____ ☐ Maternity Service ☐ CHIP
Ins. ID: _____ **Receiving** ☐ WIC ☐ HUD ☐SNAP

BILLING
☐ **S5190HD** (Prenatal Only, 1 Time Per Case)
☐ **T1016HD** ☐ **T1016HDU1** Care Coordination ____ (15 Mins. Units)

☐ Closed Case ☐ Lost to Follow-up ☐ Refused Further Service ☐ Death
☐ Spontaneous Abortion ☐ Induced Abortion ☐ Moved Out-of-State
☐ Transferred ☐ Closed by RCC Effective Date: ___ /___ /_____

ENHANCED SERVICES – PRENATAL/POSTPARTUM
S9442HD Health Education/Childbirth Classes ____ (1 Session Per Day)
☐ Maternal/Fetal Development ☐ Relaxation/Breathing Tech.
☐ Nutrition/Fitness/Drugs ☐ Postpartum/Family Planning
☐ Physiology of Labor/Delivery ☐ Newborn Care/Breastfeeding

S9444HD Health Education/Parenting Classes ____ (1 Session Per Day)
☐ Infant Care ☐ Child Safety ☐ Preventative Care
☐ S/S Acute Illness ☐ Newborn Development

S9445HD Health Education/Preventive Self Care ____ (1 Session Per Day)
☐ Physical/Emotional Changes ☐ Breastfeeding ☐ Contraceptive Care
☐ Warning Signs in Pregnancy ☐ Smoking Assessment
☐ Eating Habits ☐ Safety/Domestic Violence ☐ Healthy Behaviors

BREASTFEED
Are you currently breastfeeding? ☐ Yes ☐ N/A ☐ Never breastfed
☐ No, stopped on ___ /___ /_____
Do you exclusively breastfeed (breast milk only, including pumped)?
☐ Yes ☐ No ☐ N/A

SAFE SLEEP ASSESSMENT AND EDUCATION

Does your baby have a crib, bassinet, or Pack & Play to sleep in? ☐Yes ☐ No
Does your baby:
a. Always sleep alone in a crib, bassinet, or Pack & Play? ☐ Yes ☐ No
b. Always get placed to sleep on his/her back? ☐ Yes ☐ No
c. Always sleep in a crib, bassinet, or Pack & Play that is free of soft bedding including heavy or loose blankets, pillows, toys, or other objects? ☐ Yes ☐ No
d. Always sleep in a crib, bassinet, or Pack & Play that is free of bumper pads? ☐ Yes ☐ No
Does your baby ever sleep with anyone in an adult bed, couch, recliner, etc.? ☐ Yes ☐ No
If DCC provided safe sleep education during home visit, was the caregiver engaged in face-to-face discussion with the DCC (including Q&A) about the educational materials? ☐ Yes ☐ No ☐ Education not provided at this visit.
If DCC provided Period of Purple Crying education during the visit, was the caregiver engaged in face-to-face discussion with the DCC (including Q&A) about the educational material? ☐ Yes ☐ No ☐ Education not provided at this visit.

"I received a face-to-face visit by the DCC today." ☐ Verbal consent provided by the client due to virtual visit

Client Signature: _____ Date: _____ DCC Signature: _____ Date: _____