MIECHV Home Visit
Postnatal Encounter
Birth-12 months

Home Visitor: _____
Date of Visit: _____
Child's DOB:_____Child's Age: ____

Complete at each Postnatal Visit (Birth -12 months)

After Postnatal Intake

Parent/Caregiver First Name:	**Parent/Caregiver Last Name:**
Index children participating in visit (***use additional Child Information sheets if more than 1 child):***	

Scheduled Home Visit Completion		
☐ Completed	Start Time: _____ am/pm Miles Driven: _____ one-way Length of Visit: _____minutes Driving Time: _____ minutes Location: ☐ Family home ☐ Relative's home ☐ HV Office/center ☐ Other:	
☐ Attempted	Reason: ☐ Participant not home ☐ Participant Refused ☐ Participant/child not available ☐ Other:	Reschedule Date:
☐ Cancelled by:	☐ Family: ☐ Illness ☐ Schedule Conflict ☐ Other: ☐ Home Visitor: ☐ Illness ☐ Schedule Conflict ☐ Other:	Reschedule Date:

POSTNATAL VISIT (Birth – 12 months)

1. Are you currently smoking or using tobacco products?
   ☐ Smoking Cigarettes ☐ Using Tobacco Products ☐ E-Cigarettes
   (*Home Visitor should provide referral to tobacco cessation service if using tobacco)*
2. If smoking, how many cigarettes per day? _____
3. Are you interested in reducing/quitting? ☐ Yes ☐ No
4. Is your baby ever around tobacco smoke inside or outside your home? ☐ Yes ☐ No
5. Which of the following statements best describes the rules about smoking inside your home now, even if no one who lives in your home is a smoker?
   ☐ No one is allowed to smoke anywhere inside my home
   ☐ Smoking is allowed in some rooms or at some times
   ☐ Smoking is permitted anywhere inside my home
6. Do you have Health Insurance at this time? ☐ Yes ☐ No *(Home Visitor should provide enrollment information if not currently insured)*
7. Are you currently breastfeeding?
   ☐ Yes ☐ No (if no, date stopped):_____ ☐ Never breastfed ☐ N/A
8. Do you exclusively breastfeed (breast milk only, including pumped)? ☐ Yes ☐ No
9. Did you attend a postpartum visit after delivery? ☐ Yes, date of visit: _____ ☐ No ☐N/A

Child Information* (*use additional Child Information sheets if more than 1 child):

10. Any concerns regarding your child's :
    a. Development ☐ Yes ☐ No
    b. Behavior ☐ Yes ☐ No
    c. Learning ☐ Yes ☐ No
11. Did your child receive the Well-Child Visit at _____ weeks/months? ☐ Yes ☐ No
12. How many days during a typical week were you able to:
    a. Read to/with your child? _____
    b. Tell stories to/with your child? _____
    c. Sing songs to/with your child? _____
13. Has your child been to the Emergency Department due to an injury since our last visit? ☐ Yes ☐ No
14. If yes, how many visits? _____
15. Does your baby have a crib, bassinet, or Pack & Play to sleep in? ☐ Yes ☐ No

16. 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, and/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
17. Does your baby ever sleep with anyone in an adult bed? ☐ Yes ☐ No
18. If home visitor provided safe sleep education during the home visit, was the caregiver engaged in face-to-face discussion with the home visitor (including Q&A) about the educational materials?
    ☐ Yes ☐ No ☐ Education was not provided at this visit

SCREENING & ASSESSMENTS COMPLETED *(check all that apply)*

☐ Demographic Update ☐ Relationship Assessment ☐ Edinburgh Depression
☐ ASQ-3 ___mos. ☐ ASQ: SE _____ mos. ☐ KIPS ☐HITS (males only)

HOME VISIT SUMMARY

Referrals/Resources Initiated: ☐ Yes ☐ No
Referrals/Resources Follow-up: ☐ N/A ☐ Complete ☐ Not Complete

Materials left:

Next Visit Date:

Others involved in home visit: ☐ Father of child ☐ Mother of child ☐ Additional Caregiver
☐ Grandparent ☐ Child welfare staff ☐ Birth to Three Staff ☐ RFTS
☐ Other Adult(s) (provide #):____
☐ Other children (provide #):____