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 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, buprenorphine, oxycodone, morphine, heroin) ☐Marijuana ☐Caffeine
☐Mercury ☐Pesticides ☐Nicotine (tobacco products, vape) ☐Other drugs, please specify: _____
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 DEPRESSON (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.**