

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

OUTCOME MEASURES AT CASE CLOSURE PRENATAL



Infant 1 Infant 2 Infant 3 Infant 4	Last	First	MI		
Does client have a medical home (i.e. primary care physician)?	Client Name:				
Does client have a medical home (i.e., primary care physician)?	Infant 1 □; Infant 2 □; Infant 3 □; Infant 4 □		Did client fulfill service care plan goals? ☐ Y	es □ No	
Does client have a dental home?	HEALTH CARE				
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 Was education on contraception and spacing between children provided to the client? Yes No No Was education on contraception and spacing between children provided to the client? Yes No Still pregnant Prefer not to answer If yes, select option (check all that apply): Yes No Still pregnant Prefer not to answer If yes, select option (check all that apply): If no, was the client referred to the Family Planning Other, please specify: If no, was the client referred to the Family Planning Program? Weeks No Idlant is still pregnant, how many newesk pregnant? Weeks No Weeks	Does client have a medical home (i.e. primary of	care physician)?	□Ye	es 🗆 No	
Did client receive a Tday vaccine during this pregnancy? Did client receive a flu vaccine during this pregnancy? Did client receive a flu vaccine during this pregnancy? Was education on contraception and spacing between children provided to the client? Pers No Still pregnant Prefer not to answer Feet control of the client? Does client currently use some form of contraception (check one)? 100	Does client have a dental home?		□Ye	es 🗆 No	
Did client receive a flu vaccine during this pregnancy?	How often does client go to dental appointmen	nts (check one)? 🗆 Ev	·		
Was education on contraception and spacing between children provided to the client? Yes No Still pregnant Prefer not to answer If yes, select option (check all that apply):		•	□ Ye	es 🗆 No	
Does client currently use some form of contraception (check one)?		•		es 🗆 No	
If yes, select option (check all that apply): If uD					
UDD Implant Birth Control Pill Vaginal Ring Shot Patch Male condom Diaphragm Natural family planning Tubal Ligation Other, please specify: (weeks) If no, was the client referred to the Family Planning Program? (weeks) (weeks	•	eption (check one)?	☐ Yes ☐ No ☐ Still pregnant ☐ Prefer not to	answer	
Natural family planning					
If fo, was the client referred to the Family Planning Program?					
If client is still pregnant, how many weeks pregnant? In what month was client's initial prenatal visit? In what month was client's initial prenatal pointments has the client attended? Client used supplements during pregnancy (check all that apply)? In a multiple birth, did this pregnancy also result in (check one): In a multiple birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): In what will be birth, did this pregnancy also result in (check one): If yes, what substance(s)? (check all that apply): If a multiple birth, did this pregnancy also result in (check all that apply): If yes, what substance(s)? (check all that apply): If yes, what substance(s)? (check all that apply): If yes, what type of treatment for substance use? If yes, what type of treatment (check all that apply): If yes, what type of treatment (check all that apply): If yes, who and what substances: If client used tobacco products at enrollment, did client (check one): If yes, who and what substances: If client used tobacco products at enrollment, did client (check one): If yes, who and what substances: If client used tobacco products at enrollment, did client (check one): If ye					
In what month was client's initial prenatal visit?					
How many prenatal appointments has the client attended?					
Client used supplements during pregnancy (check all that apply)? Golic acid Prenatal/Multivitamins 2 or fewer times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 3 or 4 times per week 4 or more times per week 5 or more times per week 6 or more times per	•				
Folic acid Prenatal/Multivitamins 2 or fewer times per week 3 or 4 times per week Irregularly High-risk pregnancy? Was this birth a: If a multiple birth, did this pergenancy also result in (check one): Yes No Multiple (#): Live birth Liv	* * * * * * * * * * * * * * * * * * * *			numenus	
High-risk pregnancy? Was this birth a:		eck all that apply):		or wook	
High-risk pregnancy? Was this birth a:	- Folic acid Frenataly Multivitarinis		·	oci week	
Yes No Singleton birth Miscarriage (> 20 weeks) Stillborn (< 20 weeks) Stillborn	High-risk pregnancy? Was this hir	th a· If a		one).	
SUBSTANCE USE During pregnancy, did client drink alcohol?				one,.	
During pregnancy, did client drink alcohol? fyes, 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: Gestational Age: Quit use Neither If client quit, did client remain tobacco free after delivery? Yes No Did client begin using tobacco products during enrollment? Gestational Age: (weeks) No Delivery Date: J J Gestational Age: (weeks) No Delivery type (check one): Scheduled C-Section Emergency C-Section YBAC At what hospital/birthing center did client deliver? Yes No If yes, list: If yes, did client deliver a tertiary care center (e.g. a specialty hospital unit)? Yes No No If yes, list: If yes, did client deliver a tertiary care center (e.g. a specialty hospital unit)? Yes No No If yes, list: If yes, did client deliver a tertiary care center (e.g. a specialty hospital unit)? Yes No No If yes, list: If yes, did client deliver a tertiary care center (e.g. a specialty hospital unit)? Yes No No If yes, list: Infant weight: Infant weight: Infant weight: Infant weight: Infant weight:					
During pregnancy, did client drink alcohol?		- (/			
If yes, how many alcoholic drinks did she have in an average week (check one)?				s 🗆 No	
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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:		=			
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Recovery Support Services Other, please specify: Does anyone in the client's household (partner, parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)? Yes	If yes, what type of treatment (check all tha	t apply)?			
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If yes, who and what substances: If client used tobacco products at enrollment, did client (check one): If client quit, did client remain tobacco free after delivery? If client begin using tobacco products during enrollment? LABOR AND DELIVERY (IF DELIVERED) Delivery Date: J	☐ Recovery Support Services ☐ Other, plea	ase specify:			
If yes, who and what substances: If client used tobacco products at enrollment, did client (check one): If client quit, did client remain tobacco free after delivery? Did client begin using tobacco products during enrollment? LABOR AND DELIVERY (IF DELIVERED) Delivery Date:/ Gestational Age:(weeks) Infant weight: pounds ounces Delivery type (check one):	Does anyone in the client's household (partner	, parent, sibling, etc.) ι			
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Delivery Date:/ Gestational Age: (weeks) Infant weight: pounds ounces Infant length: inches Delivery type (check one):	Did client begin using tobacco products during	enrollment?	□ Ye	S U NO	
Infant weight: pounds ounces					
Delivery type (check one):					
At what hospital/birthing center did client deliver? Were there any maternal complications during labor and delivery? If yes, list: If yes, did client deliver at a tertiary care center (e.g. a specialty hospital unit)?					
Were there any maternal complications during labor and delivery? If yes, list: If yes, did client deliver at a tertiary care center (e.g. a specialty hospital unit)?		_	□ Scrieduled C-Section □ Emergency C-Section	⊔ VBAC	
If yes, list:	_				
If yes, did client deliver at a tertiary care center (e.g. a specialty hospital unit)?			⊔ וי	C3 LINU	
	If ves, did client deliver at a tertiary care cen	ter (e.g. a specialty hos	spital unit)?	es 🗆 No	
		(O. a spesially flot			

	Client:	
Was a NICLI stay required?	□ Voc □ N	
Was a NICU stay required?	☐ Yes ☐ N	O
If yes, number of days:	cluding caffeine, mercury, pesticides)?	
Was the infant exposed to substances during pregnancy (exc Was the infant diagnosed with Neonatal Abstinence Syndron		
was the illiant diagnosed with Neonatal Abstillence Syndron	ille!	U
BREASTFEEDING (IF DELIVERED)		
Has the infant ever breastfed (including breastmilk supplement	ented with formula)?	o
Was the infant exclusively breastfed?	□ Yes □ N	0
If yes, how long was the infant exclusively breastfed?	month	ıS
If no, was infant exclusively fed formula?	□ Yes □ N	0
If eating solid food, at what age did infant start (includes cere	eal mixed in bottle; check one)?	
	\square 0-3 months \square 4-6 months \square 7-12 month	าร
Does infant have difficulty feeding: from bottle?	□ Yes □ N	0
from breast?	□ Yes □ N	0
If mother was advised not to breastfeed, reason:	☐ Medical reasons ☐ Substance us	e
If breastfeeding stopped, what were the reasons (check all the	nat apply):	
☐ Infant had difficulty latching or nursing	\square Mother was not producing enough milk/her milk dried up	
$\hfill \square$ Breast milk alone did not satisfy the baby	☐ Mother had too many other household duties	
☐ Infant was not gaining enough weight	☐ Mother felt it was the right time to stop breastfeeding	
☐ Mother's nipples got sore, cracked or bleeding	☐ Mother became sick and had to stop for medical reasons	
\square It was too hard, painful or too time consuming	☐ Mother went back to work or school	
☐ Infant was jaundiced	☐ Infant was living with another caretaker not mother	
☐ Substance use	☐ Discouragement from friends/family	
☐ Other:		_
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	2
D	CC USE ONLY	
MEDICAL CONDITIONS	CC 03L ONL!	
Did client have any of the following medical condition during	her pregnancy (check all that apply)?	10
☐ Gestational Diabetes ☐ Pregnancy Induced Hyperter		
□ Vaginal Bleeding □ STIs	□ Preeclampsia □ Other, specify:	
If yes, did client receive treatment for this condition(s) wh		
Was education provided to client on medical conditions?	☐ Yes ☐ N	
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:	
Pogion: Agency	Country	
Region: Agency:	County:	

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