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

Client Name: Last First MI

Birthdate (mm/dd/yyyy): _____/_____/_____ Did client fulfill service care plan goals? ☐Yes ☐No

Caretaker Name: Last First MI

Relationship to Infant (check one): ☐Mother ☐Father ☐Grandparent ☐Foster Parent ☐Other Family ☐Other, please specify: _____

FEEDING/BREASTFEEDING

Has the infant ever breastfed (including breastmilk supplemented with formula; check one)? ☐Yes ☐No ☐Unknown
Was the infant ever exclusively breastfed (check one)? ☐Yes ☐No ☐Unknown
If yes, how long was the infant exclusively breastfed? _____ months
If no or unknown, 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 ☐Unknown
Does infant have difficulty feeding: from bottle? ☐Yes ☐No
from breast? ☐Yes ☐No
If mother was advised not to breastfeed, reason (check one): ☐Medical reasons ☐Substance use ☐Unknown
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 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
- ☐Unknown

HEALTH REVIEW

Infant's weight at closure: _____ pounds _____ ounces Infant's length at closure: _____ inches
Does infant have a medical home? ☐Yes ☐No
Primary location for child's regular medical checkups and sick care (check one):
☐Doctor's/nurse practitioner's office ☐Hospital emergency room ☐Hospital outpatient
☐Federally qualified health center ☐Retail store or minute clinic ☐Unknown/did not report ☐None
☐Other (please specify): _____
Has infant kept all 8 well child visits with primary care provider, up to current age? ☐Yes ☐No
Did client attend the following recommended dates of well-child visits (check all that apply):
☐5 days ☐1 month ☐2 months ☐4 months ☐6 months ☐9 months ☐12 months
Immunizations up to date? ☐Yes ☐No Date last received immunizations: _____
If not up to date, please specify why not: _____
Does anyone in the client's household (parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)? ☐Yes ☐No
If yes, what substances: _____

ORAL HEALTH

Infant has access to dental care? ☐Yes ☐No
Infant had his/her first dental appointment? ☐Yes ☐No
Has the infant's medical care provider had a conversation with the caretaker about age one (1) dental visit? ☐Yes ☐No
Does infant have any teeth at case closure? ☐Yes ☐No
Does infant have fluoride exposure via drinking water, supplements, professional applications or toothpaste? ☐Yes ☐No
Does infant drink/eat sugary foods i.e. juice, carbonated or non-carbonated soft drinks, energy drinks? ☐Yes ☐No
Did caretaker receive infant oral health education by RFTS provider? ☐Yes ☐No
Is brushing teeth, flossing, and/or cleaning gums a part of the child's daily routine? (check one): ☐Always ☐Sometimes ☐Never
Does infant fall asleep with a bottle? (check one): ☐Always ☐Sometimes ☐Never
Does guardian have concerns about the child's teeth or gums? ☐Yes ☐No
If yes, please specify concerns about the teeth or gums: _____

DCC USE ONLY

DETAILED HEALTH REVIEW

Medical conditions (check all that apply):

- ☐ Acquired immunodeficiency syndrome (AIDS)
- ☐ Asthma and respiratory allergies
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Congenital heart disease
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Digestion disorders
- ☐ Down syndrome
- ☐ Emotional/mental health disorders
- ☐ Feeding difficulties in early childhood
- ☐ Genetic disorders
- ☐ Hearing impairment
- ☐ Heart disease/defects
- ☐ Human immunodeficiency virus (HIV)
- ☐ Juvenile arthritis
- ☐ Jaundice
- ☐ Overweight and obesity
- ☐ Prematurity and low birth weight
- ☐ Sickle cell anemia/disease
- ☐ Spina bifida/neural tube defects
- ☐ Visual impairment
- ☐ Other (please specify): _____

Developmental conditions (check all that apply):

- ☐ Acquired brain injury and selected neurological disorders
- ☐ Motor delay and movement disorders
- ☐ Sensory processing disorder
- ☐ Other (please specify): _____

Allergies (check all that apply):

☐ Environmental ☐ Food ☐ Medicines ☐ Other (please specify): _____

Medicines and supplements taken regularly (check all that apply):

☐ Over-the-counter drugs ☐ Ear drops ☐ Vitamin supplements ☐ Antibiotics ☐ Eye ointment
☐ Asthma inhalers ☐ Other (please specify): _____

According to the health care provider, is child's size and weight OK? ☐ Yes ☐ No
If no, please specify concerns about child's size or weight: _____

Child has been screened for anemia? ☐ Yes ☐ No ☐ Unknown
If yes, please specify results of anemia screening: _____

Child has been screened for lead levels? ☐ Yes ☐ No ☐ Unknown
If yes, please specify results of lead screening: _____

SAFETY REVIEW

There is at least one working smoke detector on each floor where the family resides. ☐ Yes ☐ No
Family has a plan and supplies in case of an emergency in the home or natural disaster. ☐ Yes ☐ No
Do you have any concerns about your physical living space that impact well-being or safety? ☐ Yes ☐ No
If yes, please specify: _____

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.