MIECHV Home Visit
Postnatal Encounter
13+ Months

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

Complete at each Postnatal Visit (13 months+)

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 (13 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)*

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

7. Any concerns regarding your child's :
   a. Development ☐ Yes ☐ No
   b. Behavior ☐ Yes ☐ No
   c. Learning ☐ Yes ☐ No
8. Did your child receive the Well-Child Visit at _____ weeks/months? ☐ Yes ☐ No
9. 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? _____
10. Has your child been to the Emergency Department due to an injury since our last visit? ☐ Yes ☐ No
11. If yes, how many visits? _____

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 #):____