MIECHV Home Visit
Postnatal Intake (Birth – 12 months)

Home Visitation PROGRAM
Supporting Families. Strengthening Communities.
West Virginia Department of Health and Human Resources

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

Complete at Postnatal Intake Visit

Parent/Caregiver First Name:	**Parent/Caregiver Last Name:**

Index children participating in visit (***use additional Child Information sheets if more than 1 child):***

POSTNATAL INTAKE ASSESSMENT

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 quitting/reducing? ☐ 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. Did someone discuss infant safe sleep practices with you and give you materials prior to leaving the hospital? ☐ Yes ☐ No Delivery Hospital: _____
14. Does your baby have a crib, bassinet, or Pack & Play to sleep in? ☐ Yes ☐ No
15. 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
16. Does your baby ever sleep with anyone in an adult bed? ☐ Yes ☐ No
17. 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

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SCREENING & ASSESSMENTS COMPLETED *(check all that apply)*
☐ Demographic Intake/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 #):____