Home Visitor: _____
Date of Visit: _____

Complete at Prenatal Intake Visit

(Only complete 1 time)

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

PRENATAL INTAKE ASSESSMENT

1. What is your due date? (mm/dd/yyyy) _____

2. Are you currently smoking or using tobacco products? *(check all that apply)*
   ☐ Smoking Cigarettes ☐ Using Tobacco Products ☐ E-Cigarettes
   (*Home Visitor should provide a referral to a tobacco cessation service if using tobacco)*
3. If smoking, how many cigarettes per day? _____
4. Are you interested in quitting/reducing? ☐ Yes ☐ No
5. Do you have Health Insurance at this time? ☐ Yes ☐ No
   (Home Visitor should provide enrollment information if not currently insured)
6. Will you have a crib, bassinet or pack and play in your home by the time the baby is born? ☐ Yes ☐ No ☐ Don't Know
7. Did Home Visitor have face-to-face verbal <u>discussion</u> about infant safe sleep with the parent/caregiver at the visit? ☐ Yes ☐ No ☐ Don't Know
8. Did the Home Visitor give infant safe sleep materials to the parent/caregiver at the visit?
   ☐ Yes ☐ No

SCREENING & ASSESSMENTS COMPLETED *(check all that apply)*

☐ Demographic Intake ☐ Relationship Assessment ☐ Edinburgh Depression
☐ HITS (males only)

HOME VISIT SUMMARY

Referrals/Resources Initiated: ☐ Yes ☐ No

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 #):____