



# Babies First! Encounter/Data Form



<b>Client Primary Tab</b>	Local ID		LAST NAME		FIRST NAME		Middle Name	
	DATE OF BIRTH		GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Confidential address / telephone?		<input type="checkbox"/> Update to address / telephone?	
	PHYSICAL ADDRESS TYPE <input type="checkbox"/> Home <input type="checkbox"/> Homeless <input type="checkbox"/> Unknown							
	PHYSICAL ADDRESS				Apt. No.	CITY, OREGON		ZIP
	MAILING ADDRESS (if different from physical address)				Apt. No.	CITY, OREGON		ZIP
	PRIMARY TELEPHONE TYPE <input type="checkbox"/> Home <input type="checkbox"/> Message <input type="checkbox"/> No Phone <input type="checkbox"/> Work <input type="checkbox"/> Pager <input type="checkbox"/> Cell Phone					Guardian Last Name		
	PRIMARY TELEPHONE NO.			Alternate Telephone No.			Guardian First Name	
	RACE (Check all that apply) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White					Middle Name		
	ETHNICITY <input type="checkbox"/> No-Not Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Yes-Hispanic					Guardian Type		
	SPOKEN LANGUAGE		WRITTEN LANGUAGE		Medicaid No.		Deceased Date	

<b>Client Info Tab</b>	State ID	Income	Interval <input type="checkbox"/> Week <input type="checkbox"/> Bimonthly <input type="checkbox"/> Month <input type="checkbox"/> Annual	Family Size	Concurrent Program Enrollment <input type="checkbox"/> Healthy Start <input type="checkbox"/> WIC <input type="checkbox"/> NFP <input type="checkbox"/> Babies First <input type="checkbox"/> MCM <input type="checkbox"/> CaCoon		
	Insurance Status at Intake (Check all that apply) <input type="checkbox"/> OHP Standard <input type="checkbox"/> OHP Plus <input type="checkbox"/> CAWEM <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Other <input type="checkbox"/> None						SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Billing Name - First			Billing Name - Last			

<b>Babies First! Case Tab</b>	CASE START DATE		CASE MANAGER					
	Who referred client to this program? <input type="checkbox"/> 1-WIC <input type="checkbox"/> 2-Babies First! <input type="checkbox"/> 3-CaCoon <input type="checkbox"/> 4-OMC <input type="checkbox"/> 5-MCM <input type="checkbox"/> 6-PH Other <input type="checkbox"/> 7-Healthy Start <input type="checkbox"/> 8-SafeNet <input type="checkbox"/> 9-NFP <input type="checkbox"/> 11-Hospital <input type="checkbox"/> 12-EI / ECSE <input type="checkbox"/> 13-Self <input type="checkbox"/> 79-PCP <input type="checkbox"/> Other _____ (See codes)			Date referred		Risk Factors  / / / / /  <input type="checkbox"/> Check if first birth		
	Birth Weight	Pounds / Ounces	Grams	OR	Birth Length	Inches	Cm	Gestational Age at Birth (weeks)
	Data Notes							

Last Name	First Name	Middle Name	Date of Birth
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Visit Tab 1

<b>VISIT DATE</b>		<b>HOME VISITOR</b>			
Weight Today	Pounds / Ounces	Grams	Length Today	Inches	Cm
		<b>OR</b>			<b>OR</b>
Client's Immunization Status					
<input type="checkbox"/> Complete or up-to-date (has all recommended shots)		<input type="checkbox"/> None (has none of the recommended shots)			
<input type="checkbox"/> Delayed (has some of the recommended shots)		<input type="checkbox"/> Declined / Refused (declines or refuses recommended shots)			
Breastfeeding started		Still breastfeeding		Age when formula or solids first introduced	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> NA _____ weeks	

Visit Tab 2

<b>Issues / Outcomes</b>	<b>Interventions</b>
<b>Nutrition (NU)</b>	
<input type="radio"/> Meets body requirements	<input type="checkbox"/> Individual Teaching
<input type="radio"/> Less than body requirements	<input type="checkbox"/> Case Management
<input type="radio"/> More than body requirements	<input type="checkbox"/> Nutritional Monitoring
<input type="checkbox"/> Breastfeeding Assistance	
<b>Injury (IN)</b>	
<input type="radio"/> Not at risk for injury	<input type="checkbox"/> Individual Teaching
<input type="radio"/> At risk for injury	<input type="checkbox"/> Case Management
	<input type="checkbox"/> Safe Sleep
	<input type="checkbox"/> Safety Checklist
<b>Parenting (PA)</b>	<b>*Impaired parenting: the inability of the parent or primary caregiver to create, maintain, or regain an environment that promotes optimum growth and development of the child.</b>
<input type="radio"/> Readiness for enhanced parenting	<input type="checkbox"/> Individual Teaching
<input type="radio"/> At risk for impaired attachment	<input type="checkbox"/> Case Management
<input type="radio"/> Impaired parenting*	<input type="checkbox"/> Promoting First Relationships <sup>®</sup>
	<input type="checkbox"/> Attachment Promotion
	<input type="checkbox"/> NCAST <sup>®</sup>
	<input type="checkbox"/> H.O.M.E. <sup>®</sup>
<b>Child Development (CD)</b>	
<input type="radio"/> Has age-appropriate pattern of development	<input type="checkbox"/> Individual Teaching
<input checked="" type="radio"/> Appropriate development progression for condition	<input type="checkbox"/> Case Management
<input type="radio"/> At risk for delayed development	<input type="checkbox"/> RDSI <sup>®</sup>
<input type="radio"/> Delayed development	<input type="checkbox"/> IMS <sup>®</sup>
	<input type="checkbox"/> Vision Questionnaire
	<input type="checkbox"/> Hearing Questionnaire
	<input type="checkbox"/> H.O.M.E. <sup>®</sup>
	<input type="checkbox"/> Developmental Enhancement
	<input type="checkbox"/> ASQ <sup>®</sup>
	<input type="checkbox"/> Reflexes
	<input type="checkbox"/> M-CHAT <sup>®</sup>
<b>Well Child Care (WC)</b>	<b>*Medical home: the client has a partnership with a primary care provider for health care, including prevention services and access to consultation after hours and on weekends.</b>
<input type="radio"/> Has medical home*	<input type="checkbox"/> Individual Teaching
<input type="radio"/> No medical home*	<input type="checkbox"/> Case Management
<input type="radio"/> Up to date on well child care (WU)	
<input type="radio"/> Not up to date on well child care	
<b>Insurance (IS)</b>	
<input type="radio"/> OHP Standard	<input type="checkbox"/> Individual Teaching
<input type="radio"/> OHP Plus	<input type="checkbox"/> Case Management
<input type="radio"/> CAWEM	
<input type="radio"/> Indian Health Service	
<input type="radio"/> Other	
<input type="radio"/> None	
<b>OHP Follow-Up Information (OF)</b>	
<input type="radio"/> Client refused referral	
<input type="radio"/> OHP Pended	
<input type="radio"/> OHP Denied	

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<b>Issues / Outcomes</b> <b>Oral Health (OH)</b> <input type="radio"/> No identified risk factors for dental caries <input type="radio"/> At risk for dental caries <input type="radio"/> Dental caries	<b>Interventions</b> <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Oral Health Screening <input type="checkbox"/> Fluoride Varnish Application
<b>Tobacco (TO)</b> <input type="radio"/> Yes <input type="radio"/> No Secondhand smoke exposure	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> 5As Clinical Guidelines
<b>Household smoking rules (inside home at any time / on any occasion)</b> <input type="checkbox"/> No smoking allowed anywhere inside <input type="checkbox"/> Smoking allowed in some rooms <input type="checkbox"/> Smoking permitted anywhere inside	

Visit Tab 3

Referrals Out (Check all that apply.)	Referral Follow-Up (Use this "Referral Follow-Up" field to record the outcome of referrals you made.)	Reason Case Closed *
12 - EI <input type="checkbox"/> Referred	12 - EI <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 01 - Declined services
53 - Immunizations <input type="checkbox"/> Referred	53 - Immunizations <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 02 - Unable to locate
79 - Primary Provider <input type="checkbox"/> Referred	79 - Primary Provider <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 03 - Family moved out of state
90 - SSI <input type="checkbox"/> Referred	90 - SSI <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 04 - Child deceased
94 - TANF <input type="checkbox"/> Referred	94 - TANF <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 05 - Child no longer age eligible
1 - WIC <input type="checkbox"/> Referred	1 - WIC <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 06 - Child moved out of county
Other _____ (See codes) <input type="checkbox"/> Referred	Other _____ (See codes) <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 07 - Child no longer needs services
Other _____ (See codes) <input type="checkbox"/> Referred	Other _____ (See codes) <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 08 - Passive decline
Other _____ (See codes) <input type="checkbox"/> Referred	Other _____ (See codes) <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 09 - Unable to visit/case load limitations
Other _____ (See codes) <input type="checkbox"/> Referred	Other _____ (See codes) <input type="checkbox"/> Getting Services <input type="checkbox"/> Not eligible	<input type="checkbox"/> 10 - Transfer to CaCoon

<b>County Codes</b> / / / / / / / / / /		<input type="checkbox"/> 90 - Other
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<b>Location Code</b> <input type="checkbox"/> 1 - Home / Field <input type="checkbox"/> 2 - Hospital <input type="checkbox"/> 3 - Health Department <input type="checkbox"/> 4 - School <input type="checkbox"/> 5 - Telephone <input type="checkbox"/> 6 - Tertiary Care Evaluation <input type="checkbox"/> 7 - Group Home / Shelter <input type="checkbox"/> 8 - Client Not Home / Failed Visit <input type="checkbox"/> 9 - Other	<b>Time</b> <input type="checkbox"/> Submit TCM Claim	<b>Case Closed Date *</b>
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