

Client Primary Tab	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	

Client Info Tab	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					

CaCoon Case Tab	CASE START DATE		CASE MANAGER											
	Who referred client to this program?				Date referred			Risk Factors / / / / /						
	<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)				CaCoon Tier <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9					Does client have Early Intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Check if first birth													
	Birth Weight		Pounds / Ounces		Grams		Birth Length		Inches		Cm	Gestational Age at Birth (weeks)		
	OR											OR		
Data Notes														

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

VISIT DATE		HOME VISITOR			
Weight Today	Pounds / Ounces	Grams	Length Today	Inches	Cm
		OR			OR
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

Issues / Outcomes	Interventions
Nutrition (NU) <input type="radio"/> Meets body requirements <input type="radio"/> Less than body requirements <input type="radio"/> More than body requirements	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Nutritional Monitoring <input type="checkbox"/> Breastfeeding Assistance
Injury (IN) <input type="radio"/> Not at risk for injury <input type="radio"/> At risk for injury	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Safe Sleep <input type="checkbox"/> Safety Checklist
Parenting (PA) <input type="radio"/> Readiness for enhanced parenting <input type="radio"/> At risk for impaired attachment <input type="radio"/> Impaired parenting*	*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. <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Promoting First Relationships [®] <input type="checkbox"/> Attachment Promotion <input type="checkbox"/> NCAST [®] <input type="checkbox"/> H.O.M.E. [®]
Child Development (CD) <input type="radio"/> Has age-appropriate pattern of development <input type="radio"/> Appropriate development progression for condition <input type="radio"/> At risk for delayed development <input type="radio"/> Delayed development	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Developmental Enhancement <input type="checkbox"/> RDSI [®] <input type="checkbox"/> IMS [®] <input type="checkbox"/> ASQ [®] <input type="checkbox"/> Vision Questionnaire <input type="checkbox"/> Hearing Questionnaire <input type="checkbox"/> Reflexes <input type="checkbox"/> Pain <input type="checkbox"/> H.O.M.E. [®] <input type="checkbox"/> M-CHAT [®]
Well Child Care (WC) <input type="radio"/> Has medical home* <input type="radio"/> No medical home* <input type="radio"/> Up to date on well child care (WU) <input type="radio"/> Not up to date on well child care	*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. <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management
Insurance (IS) <input type="radio"/> OHP Standard <input type="radio"/> OHP Plus <input type="radio"/> CAWEM <input type="radio"/> Indian Health Service <input type="radio"/> Other <input type="radio"/> None	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management
OHP Follow-Up Information (OF) <input type="radio"/> Client refused referral <input type="radio"/> OHP Pended <input type="radio"/> OHP Denied	

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Issues / Outcomes Oral Health (OH) <input type="radio"/> No identified dental caries <input type="radio"/> At risk for dental caries <input type="radio"/> Dental caries	Interventions <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Fluoride Varnish Application	<input type="checkbox"/> Case Management <input type="checkbox"/> Oral Health Screening	
<input type="radio"/> No abnormal development (OD) <input type="radio"/> At risk for abnormal development <input type="radio"/> Abnormal development	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	
Access to Medical Care (AM) <input type="radio"/> Yes Family has access to medical treatment appropriate for their child's condition <input type="radio"/> No	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	<input type="checkbox"/> Health System Guidance
Community Resources (CR) <input type="radio"/> Yes Family is knowledgeable about and is able to access community support and specialized services <input type="radio"/> No	<input type="checkbox"/> Individual Teaching	<input type="checkbox"/> Case Management	<input type="checkbox"/> Sustenance Support
Family Knowledge of Chronic Condition (FK) <input type="radio"/> Yes Family is knowledgeable about their child's condition. <input type="radio"/> No	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Parenting Promotion <input type="checkbox"/> Family Assessment	<input type="checkbox"/> Case Management <input type="checkbox"/> Teaching: Disease Process	<input type="checkbox"/> Normalization Promotion <input type="checkbox"/> Child Health Assessment
Tobacco (TO) <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
Household smoking rules (inside home at any time / on any occasion) <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"/> 90 - Other
County Codes / / / / / / / / / /		
Location Code	Time	<input type="checkbox"/> Submit TCM Claim Case Closed Date*