



Maternity Case Management Encounter/Data Form or Postpartum Maternity-Other Program (MOP)

Client Primary Tab	Local ID		LAST NAME		FIRST NAME		Middle Name
	DATE OF BIRTH	GENDER	<input type="checkbox"/> Confidential address / telephone?		<input type="checkbox"/> Update to address / telephone?		
	<input type="checkbox"/> Female <input type="checkbox"/> Male						
	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					Guardian Last Name	
	<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						
	PRIMARY TELEPHONE NO.			Alternate Telephone No.		Guardian First Name	
	RACE (Check all that apply)					Middle Name	
<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							
ETHNICITY					Guardian Type		
<input type="checkbox"/> No-Not Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Yes-Hispanic							
SPOKEN LANGUAGE		WRITTEN LANGUAGE		Medicaid No.		Deceased Date	

Client Info Tab	State ID	Income	Interval	Family Size	Concurrent Program Enrollment	
			<input type="checkbox"/> Week <input type="checkbox"/> Bimonthly		<input type="checkbox"/> Healthy Start <input type="checkbox"/> WIC <input type="checkbox"/> NFP	
			<input type="checkbox"/> Month <input type="checkbox"/> Annual		<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						<input type="checkbox"/> Yes <input type="checkbox"/> No
Billing Name - First				Billing Name - Last		

MCM Case Tab	CASE START DATE	CASE MANAGER				IS PROGRAM MCM OR MOP?		
					<input type="radio"/> MCM <input type="radio"/> MOP			
	Who referred client to this program?		Date referred		Perinatal 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"/> <18 years <input type="checkbox"/> <HS Education <input type="checkbox"/> IPV			
	<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"/> 10-Family Planning				<input type="checkbox"/> Medical Risk (e.g., diabetes, hypertension, obesity)			
<input type="checkbox"/> 11-Hospital <input type="checkbox"/> 13-Self <input type="checkbox"/> 78-Prenatal Provider				<input type="checkbox"/> Mental Health <input type="checkbox"/> Nutrition <input type="checkbox"/> Substance Abuse				
<input type="checkbox"/> Other _____ (See codes)				<input type="checkbox"/> Tobacco Use <input type="checkbox"/> Unmarried				
<input type="checkbox"/> Other _____ (See codes)				<input type="checkbox"/> Unplanned Pregnancy <input type="checkbox"/> Other				
Gravida	Term	Preterm	SAB	TAB	Date of First PNC Visit	Trimester Clinical PNC Initiated	Date LMP	Est. Due Date
						<input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> None		
Data Notes								

Last Name	First Name	Middle Name	Date of Birth
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Visit Tab

VISIT DATE	HOME VISITOR		
Issues / Outcomes Prenatal Care (PC) <input type="radio"/> Receiving PNC <input type="radio"/> Not receiving PNC	Interventions <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
Breastfeeding (BF) <input type="radio"/> Has plans for breastfeeding <input type="radio"/> No plans for breastfeeding <input type="radio"/> Concerns relating to breastfeeding	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Breastfeeding Assistance (postpartum) <input type="checkbox"/> Lactation Counseling (antepartum)		
HIV Testing & Follow-Up (HI) <input type="radio"/> Tested <input type="radio"/> Needs testing <input type="radio"/> Refused testing	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
<input type="radio"/> Follow-up done (HF) <input type="radio"/> Needs follow-up	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
Hepatitis B Testing & Follow-Up (HB) <input type="radio"/> Tested <input type="radio"/> Needs testing <input type="radio"/> Refused testing	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
<input type="radio"/> Follow-up done (HU) <input type="radio"/> Needs follow-up	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
Preterm Delivery (PD) <input type="radio"/> No apparent risk of preterm labor <input type="radio"/> At risk for preterm labor <input type="radio"/> Receiving treatment for preterm labor	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
Nutrition (NU) <input type="radio"/> Yes Maternal nutrition supports healthy pregnancy <input type="radio"/> No	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique <input type="checkbox"/> Nutritional Monitoring		
Medical Home* for Non-Pregnancy-Related Health Care (MH) <input type="radio"/> Has medical home* <input type="radio"/> No medical home*	<small>*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.</small> <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
Oral Health during Pregnancy (OH) <input type="radio"/> Adequate dental care <input type="radio"/> Inadequate dental care	<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral		
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 <input type="checkbox"/> Referral		
OHP Follow-Up Information (OF) <input type="radio"/> Client refused referral <input type="radio"/> OHP Pended <input type="radio"/> OHP Denied			

Last Name	First Name	Middle Name	Date of Birth
Issues / Outcomes Intimate Partner Violence (IP) <input type="radio"/> Screened <input type="radio"/> Not screened		Interventions <input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique	
<input type="radio"/> Safety plan not needed (SP) <input type="radio"/> Client has safety plan <input type="radio"/> Refused		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique	
Alcohol Use / Substance Abuse (AS) <input type="radio"/> No history of alcohol use / substance abuse <input type="radio"/> Recent history (within last year) <input type="radio"/> Current alcohol use / substance abuse		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique	
Depression (DE) <input type="radio"/> Readiness for enhanced coping <input type="radio"/> Ineffective coping related to maternal depression		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Screening Tool	
Family Planning (FP) <input type="radio"/> Client has reproductive plan <input type="radio"/> Client does not have reproductive plan		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique	
<input type="radio"/> Client uses contraceptive method (FC) <input type="radio"/> Client does not use contraceptive method		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> Behavior Change Technique	
Tobacco Use (TO) <input type="radio"/> No history of smoking <input type="radio"/> Recent history of smoking		<input type="checkbox"/> Individual Teaching <input type="checkbox"/> Case Management <input type="checkbox"/> Referral <input type="checkbox"/> 5As Clinical Guidelines	
Attempted smoking cessation during the past 12 months <input type="checkbox"/> Yes, no longer smokes <input type="checkbox"/> Yes, didn't stay quit <input type="checkbox"/> No		Smoking frequency <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all	# cigarettes/day (20 = 1 pack)
Other household smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No	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		

Postpartum Tab

Date of Delivery	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Birth Weight	Pounds / Ounces	Grams	Birth Length	Inches	Cm
		OR				OR	
Gestational Age at Birth (weeks)	Breastfeeding started <input type="checkbox"/> Yes <input type="checkbox"/> No	Still Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Age when formula or solids first introduced <input type="checkbox"/> NA _____ weeks				
If Pregnancy Outcome Not a Live Birth <input type="checkbox"/> SAB <input type="checkbox"/> TAB <input type="checkbox"/> Stillborn		Date Pregnancy Ended	Attach additional forms for multiple births. How many forms are attached? 1 2 3 more (Circle one.)				

Billing Tab

MCM Services and Billing <input type="checkbox"/> G9001 Initial Assessment <input type="checkbox"/> G9006 Home Assessment <input type="checkbox"/> G9011 Telephone Visit <input type="checkbox"/> G9012 Case Management Visit		Location <input type="checkbox"/> Home <input type="checkbox"/> LHD (Non-FQHC) <input type="checkbox"/> Other	Dx Code _____ _____ _____
Case Management Services <input type="checkbox"/> G9002 Full Case Management <input type="checkbox"/> G9009 Partial Case Management <input type="checkbox"/> G9005 Full High Risk Case Management <input type="checkbox"/> G9010 Partial High Risk Case Management		<input type="checkbox"/> Home <input type="checkbox"/> LHD (Non-FQHC) <input type="checkbox"/> Other	_____ _____ _____ _____
Date Case Closed *	Was client lost to follow-up? <input type="checkbox"/> Yes <input type="checkbox"/> No	County Codes / / / / / / / / / /	