Babies First! and CaCoon

Oregon Health Authority

OCCYSHN
Oregon Center for Children and Youth with Special Health Needs

Every Visit Survey: Client

COMPLETE AT

- **Every visit**

Name of home visitor: _____

Name of caregiver: _____

Name of child: _____

Date of birth: _____ / _____ / _____ **Date of visit/survey date:** _____ / _____ / 20_____

1. **Visit Outcome**
   - ☐ Visit completed
   - ☐ Client no show at location ✓ END OF SURVEY
   - ☐ Client canceled ✓ END OF SURVEY
   - ☐ Home visitor canceled ✓ END OF SURVEY

2. **How long was the visit?**

   _____ minutes (15 min. increments in THEO)

3. **Encounter Participants**

   PLEASE CHECK ALL THAT APPLY AND SPECIFY AS INDICATED

   - ☐ Client
   - ☐ Other infant, child, or youth not enrolled
   - ☐ Birthing parent
   - ☐ Non-birthing parent: _____
   - ☐ Other caregiver: _____
   - ☐ Student
   - ☐ Supervisor
   - ☐ Interpreter
   - ☐ Other: _____

PLEASE CONTINUE TO NEXT PAGE

4. **Where did the visit occur?**

- ☐ Client home
- ☐ Doctor/clinic
- ☐ Family/friend's home
- ☐ School
- ☐ Public/private agency
- ☐ Public location *- example: park*
- ☐ Telephone
- ☐ Online video
- ☐ Other: _____

5. **Were TCM services billed for this visit?**

- ☐ Yes, TCM services billed at this visit
- ☐ No, TCM services not billed at this visit

6. **Has the client had a health care visit either in the past month (if this is an enrollment visit) or since their last home visit?**

FOR EXAMPLE, PNC, PP, EMERGENCY, WCC, BEHAVIORAL

- ☐ Yes
- ☐ No SKIP TO QUESTION 8
- ☐ Declined to answer SKIP TO QUESTION 8

7. **If yes, check the visit type and enter the date of the last health visit**

IF CLIENT DOESN'T KNOW SPECIFIC DAY, ENTER THE FIRST OF THE MONTH IN WHICH THE VISIT WAS MADE

- ☐ A. Adolescent well visit _____ / _____ / 20_____
- ☐ B. Behavioral/mental health _____ / _____ / 20_____
- ☐ C. Dental visit _____ / _____ / 20_____
- ☐ D. Planned hospital visit _____ / _____ / 20_____
- ☐ E. Prenatal care _____ / _____ / 20_____
- ☐ F. Primary care _____ / _____ / 20_____
- ☐ G. Specialty care _____ / _____ / 20_____
- ☐ H. Speech or physical therapy _____ / _____ / 20_____
- ☐ I. Unplanned emergency or hospital visit _____ / _____ / 20_____
- ☐ J. Well child care _____ / _____ / 20_____
- ☐ K. Well woman visit _____ / _____ / 20_____
- ☐ L. Other: _____

PLEASE CONTINUE TO NEXT PAGE

8. **Client does not have to be screened with a validated tool for these health areas at every visit, but please indicate their current needs and which intervention was done (if any).**

PLEASE CHECK ALL THAT APPLY

	Identified need for services or intervention	What kind of intervention was done? PLEASE CHECK ALL THAT APPLY			
		Referral	Education	Behavior change promotion	No intervention at this visit
A. Child Care	☐	☐	☐	☐	☐
B. Financial	☐	☐	☐	☐	☐
C. Food Security	☐	☐	☐		☐
D. Housing/Home Environment	☐	☐	☐	☐	☐
E. Medical Care—*PNC, medical home, oral health*	☐	☐	☐	☐	☐
F. Mental Health	☐	☐	☐	☐	☐
G. Safe Sleep Promotion	☐	☐	☐	☐	☐
H. Smoking Cessation	☐	☐	☐	☐	☐
I. Smoking Rules	☐	☐	☐	☐	☐
J. Social Support	☐	☐	☐	☐	☐
K. Substance Use	☐	☐	☐	☐	☐
L. Transportation	☐	☐	☐		☐
M. Violence or Abuse	☐	☐	☐	☐	☐
N. Vision/Hearing	☐	☐	☐	☐	☐

END OF SURVEY