

Client Primary Tab

Local ID	LAST NAME		FIRST NAME		Middle Name
DATE OF BIRTH	GENDER	<input type="checkbox"/> Female <input checked="" 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
MAY WE CONTACT YOU BY MAIL? <input type="checkbox"/> Yes <input type="checkbox"/> No			MAY WE CONTACT YOU BY PHONE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PRIMARY PHONE TYPE <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home <input type="checkbox"/> Message <input type="checkbox"/> No Phone <input type="checkbox"/> Unknown <input type="checkbox"/> Work		PHONE NO.	PHONE OPTIONS <input type="checkbox"/> Both Voice & Text <input type="checkbox"/> Text Only <input type="checkbox"/> Voice Only		Guardian Last Name
Alternate Phone Type <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home <input type="checkbox"/> Message <input type="checkbox"/> No Phone <input type="checkbox"/> Unknown <input type="checkbox"/> Work		Phone No.	Phone Options <input type="checkbox"/> Both Voice & Text <input type="checkbox"/> Text Only <input type="checkbox"/> Voice Only		Guardian First Name
Client E-mail		SPOKEN LANGUAGE		WRITTEN LANGUAGE	
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		ETHNICITY <input type="checkbox"/> No-Not Hispanic or Latino <input type="checkbox"/> Yes-Hispanic or Latino		Medicaid No. * Deceased Date	
Alternate Format <input type="checkbox"/> Audio Tape <input type="checkbox"/> Braille <input type="checkbox"/> Computer Disk <input type="checkbox"/> Large Print <input type="checkbox"/> Oral Presentation <input type="checkbox"/> Other					

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 checked="" type="checkbox"/> WIC <input type="checkbox"/> NFP <input checked="" type="checkbox"/> Babies First <input checked="" type="checkbox"/> MCM <input checked="" 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"/> CAWEM Plus <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Other <input type="checkbox"/> None		SSI? <input checked="" 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? <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"/> 10-Family Planning <input type="checkbox"/> 11-Hospital <input type="checkbox"/> 13-Self <input type="checkbox"/> 78-Prenatal Care Provider <input type="checkbox"/> Other (See codes)			Perinatal Risk Factors <input type="checkbox"/> <18 years <input type="checkbox"/> <HS Education <input type="checkbox"/> Developmental Disability <input type="checkbox"/> IPV <input type="checkbox"/> Medical Risk (e.g., diabetes, hypertension, obesity) <input type="checkbox"/> Mental Health <input type="checkbox"/> Nutrition <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Unmarried <input type="checkbox"/> Unplanned Pregnancy <input type="checkbox"/> Other		
Date Referred	Gravida	Term	Preterm	SAB	TAB
Date of First PNC Visit		Date LMP		Estimated Due Date	
Trimester Clinical PNC Initiated <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> None		Data Notes			

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Visit Tab

VISIT DATE	HOME VISITOR		
Issues / Outcomes	Interventions		
Basic Needs (BN) <input type="radio"/> A - Met <input type="radio"/> B - Not met	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 4 - Shelter <input type="checkbox"/> 7 - Utilities	<input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 5 - Food <input type="checkbox"/> 8 - Transportation	<input type="checkbox"/> 3 - Referral <input type="checkbox"/> 6 - \$ Assistance
Prenatal Care (PC) <input type="radio"/> A - Receiving PNC <input type="radio"/> B - Not receiving PNC	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
Breastfeeding (BF) <input type="radio"/> A - Has plans for breastfeeding <input type="radio"/> B - No plans for breastfeeding <input type="radio"/> C - Concerns relating to breastfeeding	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 4 - Breastfeeding Assistance (postpartum)	<input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 5 - Lactation Counseling (antepartum)	<input type="checkbox"/> 3 - Referral
HIV Testing & Follow-Up (HI) <input type="radio"/> A - Tested <input type="radio"/> B - Needs testing <input type="radio"/> C - Refused testing	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
<input type="radio"/> A - Follow-up done (HF) <input type="radio"/> B - Needs follow-up	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
Hepatitis B Testing & Follow-Up (HB) <input type="radio"/> A - Tested <input type="radio"/> B - Needs testing <input type="radio"/> C - Refused testing	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
<input type="radio"/> A - Follow-up done (HU) <input type="radio"/> B - Needs follow-up	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
Preterm Delivery (PD) <input type="radio"/> A - No apparent risk of preterm labor <input type="radio"/> B - At risk for preterm labor <input type="radio"/> C - Receiving treatment for preterm labor	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
Nutrition (NU) <input type="radio"/> A - Yes Maternal nutrition supports healthy pregnancy <input type="radio"/> B - No	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 4 - Behavior Change Technique	<input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 5 - Nutritional Monitoring	<input type="checkbox"/> 3 - Referral
Oral Health during Pregnancy (OH) <input type="radio"/> A - Adequate dental care <input type="radio"/> B - Inadequate dental care	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
Insurance (IS) <input type="radio"/> A - OHP Standard <input type="radio"/> B - OHP Plus <input type="radio"/> C - CAWEM <input type="radio"/> D - Indian Health Service <input type="radio"/> E - Other <input type="radio"/> F - None <input type="radio"/> G - CAWEM Plus	<input type="checkbox"/> 1 - Individual Teaching	<input type="checkbox"/> 2 - Case Management	<input type="checkbox"/> 3 - Referral
OHP Follow-Up Information (OF) <input type="radio"/> A - Client refused referral <input type="radio"/> B - OHP Pended <input type="radio"/> C - OHP Denied			

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Issues / Outcomes	Interventions
Medical Home* for Non-Pregnancy-Related Health Care (MH) <input type="radio"/> A - Has medical home* <input type="radio"/> B - No medical home*	*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"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral

Intimate Partner Violence (IP) <input type="radio"/> A - Screened <input type="radio"/> B - Not screened	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Behavior Change Technique
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<input type="radio"/> A - Safety plan not needed (SP) <input type="radio"/> B - Client has safety plan <input type="radio"/> C - Refused <input type="radio"/> D - Safety plan needed	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Behavior Change Technique
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Alcohol Use / Substance Abuse (AS) <input type="radio"/> A - No history of alcohol use / substance abuse <input type="radio"/> B - Recent history (within last year) <input type="radio"/> C - Current alcohol use / substance abuse	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Behavior Change Technique
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Depression (DE) <input type="radio"/> A - Readiness for enhanced coping <input type="radio"/> B - Ineffective coping related to maternal depression	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Screening Tool
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Family Planning (FP) <input type="radio"/> A - Client has reproductive plan <input type="radio"/> B - Client does not have reproductive plan	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Behavior Change Technique
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<input type="radio"/> A - Client uses contraceptive method (FC) <input type="radio"/> B - Client does not use contraceptive method	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - Behavior Change Technique
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Tobacco Use (TO) <input type="radio"/> A - No history of smoking <input type="radio"/> B - Recent history of smoking	<input type="checkbox"/> 1 - Individual Teaching <input type="checkbox"/> 2 - Case Management <input type="checkbox"/> 3 - Referral <input type="checkbox"/> 4 - 5As Clinical Guidelines
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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)
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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
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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*	Location <input type="checkbox"/> Home <input type="checkbox"/> LHD (Non-FQHC) <input type="checkbox"/> Other	Dx Code	County Codes
	<input type="checkbox"/> G9001 Initial Assessment		_____	
	<input type="checkbox"/> G9006 Home Assessment		_____	Estimated Date of Next Visit
	<input type="checkbox"/> G9011 Case Management Visit Outside the Home <input type="checkbox"/> G9012 Case Management HOME Visit		_____	Date Case Closed*
Case Management Services <input type="checkbox"/> G9002 Case Management <input type="checkbox"/> G9005 High Risk Case Management			Client lost to follow-up? <input type="checkbox"/> Yes	