



Oregon MothersCare
supporting healthy pregnancies

Oregon MothersCare Client Tracking Form

Record ID: _____

OMC Site Code/Name:		Date of Initial Contact:		Date of Birth:		Referred by*:		
First Name:			Preferred name*:		Phone Number (1st)*:			<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> message
Last Name:					Phone Number (2nd)*:			<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> message
Street Address*:				Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown				
Mailing Address*:				Language: <input type="checkbox"/> Cantonese <input type="checkbox"/> English <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:				
City:		Zip:		Race (check all that apply): <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown <input type="checkbox"/> Other				
Email Address*:								
Current Student?: <input type="checkbox"/> No <input type="checkbox"/> High School <input type="checkbox"/> Comm Coll <input type="checkbox"/> University <input type="checkbox"/> Other School If in Community College, Specify Name: _____								

Client Screening

LMP Date:		EDD Date*:		"High Risk" pregnancy: <input type="checkbox"/>	
Current WIC Client: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Scheduled		Gravida: _____		Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Number: _____		Para: _____		Alcohol User: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Income: _____		Abortion: _____		Drug User: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Living Child: _____		Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Breastfeeding Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Application Information

App. Submitted Date: _____		Reapply Date (same pregnancy): _____		Client's Current Maternity Insurance – (select one) <input type="radio"/> CAWEM <input type="radio"/> CAWEX <input type="radio"/> OHP <input type="radio"/> Private Insurance <input type="radio"/> Other County's CCO <input type="radio"/> <input type="radio"/> Other State's Medicaid <input type="radio"/> FFM <input type="radio"/> Other <input type="radio"/> None	
Approval: <input type="checkbox"/> OHP Approved <input type="checkbox"/> CAWEX Approved <input type="checkbox"/> QHP Approved					

Services Delivered by OMC Site (check appropriate boxes)

Date of Services:		Appt. Time*:	
<input type="checkbox"/>	Pregnancy Testing	<input type="checkbox"/>	Other Community Referrals
<input type="checkbox"/>	OHP Application Assistance	<input type="checkbox"/>	Attendance at 1st Prenatal Visit <u>before</u> OMC Confirmed
<input type="checkbox"/>	Referral to OHP Community Partner	<input type="checkbox"/>	Dental Education/Information <input type="checkbox"/> Completed Dental Referral
<input type="checkbox"/>	Prenatal Care Provider Selected	<input type="checkbox"/>	Smoking Cessation Education and Referral
<input type="checkbox"/>	PNC Appt. Scheduled/or Confirmed by OMC Site	<input type="checkbox"/>	Behavioral Health Referral Education <input type="checkbox"/> Behavioral Health Referral
<input type="checkbox"/>	Initial Prenatal Needs Assessment	<input type="checkbox"/>	Primary Care Provider Education/Information
<input type="checkbox"/>	WIC Referral/Certification	<input type="checkbox"/>	Primary Care Provider Referral (appt: _____)
<input type="checkbox"/>	Home Visiting Education/Information <input type="checkbox"/> HV Referral Completed	<input type="checkbox"/>	Transportation Referral and/or Assistance
<input type="checkbox"/>		<input type="checkbox"/>	Childbirth Class Education Enrollment/Referral

Prenatal Care Information

Has client started PNC prior to OMC? <input type="radio"/> Yes ** (**indicate date below) <input type="radio"/> No				
Name of Prenatal Care Provider or Clinic:*				
Date 1st PNC <u>before</u> OMC (**if answered Yes above):	Date PNC <u>after</u> OMC contact:			
If no date above, select reason below:				
<input type="checkbox"/> Declined	<input type="checkbox"/> Option Undecided	<input type="checkbox"/> Pending OHP Approval	<input type="checkbox"/> SAB (Miscarriage)	<input type="checkbox"/> Gave Birth
<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> Will Make Own Appts	<input type="checkbox"/> TAB (Abortion)	<input type="checkbox"/> Transferred Care	<input type="checkbox"/> Pending Clinic Response

Notes*: _____

Form Complete?

Yes No

* Indicates fields not tracked by OMC state office and are for your office use only.

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