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

Oregon Health Authority | FamilyNet

Client Primary Tab

Local ID	**LAST NAME**	**FIRST NAME**	Middle Name

DATE OF BIRTH	**GENDER** ☐ Female ☐ Male	☐ Confidential address / telephone?	☐ Update to address / telephone?

PHYSICAL ADDRESS TYPE
☐ Home ☐ Homeless ☐ 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? ☐ Yes ☐ No

MAY WE CONTACT YOU BY PHONE? ☐ Yes ☐ No

PRIMARY PHONE TYPE	**PHONE NO.**	**PHONE OPTIONS**
☐ Cell Phone ☐ Home ☐ Message ☐ No Phone ☐ Unknown ☐ Work		☐ Both Voice & Text ☐ Text Only ☐ Voice Only
Alternate Phone Type ☐ Cell Phone ☐ Home ☐ Message ☐ No Phone ☐ Unknown ☐ Work	Phone No.	Phone Options ☐ Both Voice & Text ☐ Text Only ☐ Voice Only

Client E-mail

Guardian Last Name	Guardian First Name
Guardian Middle Name	Guardian Type

SPOKEN LANGUAGE

WRITTEN LANGUAGE

Alternate Format
☐ Audio Tape ☐ Braille ☐ Computer Disk
☐ Large Print ☐ Oral Presentation ☐ Other

RACE (Check all that apply.)
☐ American Indian/Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White

ETHNICITY
☐ No-Not Hispanic or Latino
☐ Yes-Hispanic or Latino

Medicaid No. *

Deceased Date

Client Info Tab

State ID	Income	Interval	Family Size	Concurrent Program Enrollment
		☐ Week ☐ Bimonthly ☐ Month ☐ Annual		☐ Healthy Start ■ WIC ☐ NFP ■ Babies First ■ MCM ■ CaCoon

Insurance Status at Intake (Check all that apply.)
☐ OHP Standard ☐ OHP Plus ☐ CAWEM ☐ CAWEM Plus
☐ Indian Health Service ☐ Other ☐ None

SSI? ☐ Yes ☐ No

Billing Name - First

Billing Name - Last

MCM Case Tab

CASE START DATE	**CASE MANAGER**	**IS PROGRAM MCM OR MOP?** ◯ MCM ◯ MOP

Who referred client to this program?
☐ 1-WIC ☐ 2-Babies First! ☐ 3-CaCoon ☐ 4-OMC
☐ 5-MCM ☐ 6-PH Other ☐ 7-Healthy Start ☐ 8-SafeNet
☐ 9-NFP ☐ 10-Family Planning ☐ 11-Hospital ☐ 13-Self
☐ 78-Prenatal Care Provider
☐ Other _____ (See codes)

Perinatal Risk Factors
☐ <18 years ☐ <HS Education ☐ Developmental Disability
☐ IPV ☐ Medical Risk (e.g., diabetes, hypertension, obesity)
☐ Mental Health ☐ Nutrition ☐ Substance Abuse
☐ Tobacco Use ☐ Unmarried ☐ Unplanned Pregnancy
☐ Other

Date Referred	Gravida	Term	Preterm	SAB	TAB	Date of First PNC Visit

Trimester Clinical PNC Initiated	Date LMP	Estimated Due Date
☐ First ☐ Second ☐ Third ☐ None		

Data Notes

Last Name	First Name	Middle Name	Date of Birth

Visit Tab

VISIT DATE | **HOME VISITOR**

Issues / Outcomes | Interventions

Basic Needs (BN)
- ◯ A - Met
- ◯ B - Not met

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Shelter ☐ 5 - Food ☐ 6 - $ Assistance
☐ 7 - Utilities ☐ 8 - Transportation

Prenatal Care (PC)
- ◯ A - Receiving PNC
- ◯ B - Not receiving PNC

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Breastfeeding (BF)
- ◯ A - Has plans for breastfeeding
- ◯ B - No plans for breastfeeding
- ◯ C - Concerns relating to breastfeeding

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Breastfeeding Assistance (postpartum) ☐ 5 - Lactation Counseling (antepartum)

HIV Testing & Follow-Up (HI)
- ◯ A - Tested
- ◯ B - Needs testing
- ◯ C - Refused testing

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

- ◯ A - Follow-up done (HF)
- ◯ B - Needs follow-up

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Hepatitis B Testing & Follow-Up (HB)
- ◯ A - Tested
- ◯ B - Needs testing
- ◯ C - Refused testing

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

- ◯ A - Follow-up done (HU)
- ◯ B - Needs follow-up

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Preterm Delivery (PD)
- ◯ A - No apparent risk of preterm labor
- ◯ B - At risk for preterm labor
- ◯ C - Receiving treatment for preterm labor

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Nutrition (NU)
- ◯ A - Yes
- ◯ B - No

Maternal nutrition supports healthy pregnancy

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique ☐ 5 - Nutritional Monitoring

Oral Health during Pregnancy (OH)
- ◯ A - Adequate dental care
- ◯ B - Inadequate dental care

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Insurance (IS)
- ◯ A - OHP Standard
- ◯ B - OHP Plus
- ◯ C - CAWEM
- ◯ D - Indian Health Service
- ◯ E - Other
- ◯ F - None
- ◯ G - CAWEM Plus

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

OHP Follow-Up Information (OF)
- ◯ A - Client refused referral
- ◯ B - OHP Pended
- ◯ C - OHP Denied

Continued on next page . . .

Last Name	First Name	Middle Name	Date of Birth

Issues / Outcomes — Interventions

Medical Home* for Non-Pregnancy-Related Health Care (MH)

- ◯ A - Has medical home*
- ◯ 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.

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral

Intimate Partner Violence (IP)

- ◯ A - Screened
- ◯ B - Not screened

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique

- ◯ A - Safety plan not needed (SP)
- ◯ B - Client has safety plan
- ◯ C - Refused
- ◯ D - Safety plan needed

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique

Alcohol Use / Substance Abuse (AS)

- ◯ A - No history of alcohol use / substance abuse
- ◯ B - Recent history (within last year)
- ◯ C - Current alcohol use / substance abuse

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique

Depression (DE)

- ◯ A - Readiness for enhanced coping
- ◯ B - Ineffective coping related to maternal depression

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Screening Tool

Family Planning (FP)

- ◯ A - Client has reproductive plan
- ◯ B - Client does not have reproductive plan

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique

- ◯ A - Client uses contraceptive method (FC)
- ◯ B - Client does not use contraceptive method

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - Behavior Change Technique

Tobacco Use (TO)

- ◯ A - No history of smoking
- ◯ B - Recent history of smoking

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Referral
☐ 4 - 5As Clinical Guidelines

Attempted smoking cessation during the past 12 months
☐ Yes, no longer smokes ☐ Yes, didn't stay quit ☐ No

Smoking frequency
☐ Every day ☐ Some days ☐ Not at all

cigarettes/day (20 = 1 pack)

Other household smokers?
☐ Yes ☐ No

Household smoking rules (inside home at any time / on any occasion)
☐ No smoking allowed anywhere inside ☐ Smoking allowed in some rooms ☐ Smoking permitted anywhere inside

Postpartum Tab

Date of Delivery	Sex ☐ Female ☐ Male	Birth Weight	Pounds / Ounces **OR** Grams	Birth Length	Inches **OR** Cm

Gestational Age at Birth (weeks)	Breastfeeding started ☐ Yes ☐ No	Still Breastfeeding ☐ Yes ☐ No	Age when formula or solids first introduced ☐ NA _____ weeks

If Pregnancy Outcome Not a Live Birth
☐ SAB ☐ TAB ☐ 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: ☐ Home ☐ LHD (Non-FQHC) ☐ Other

Dx Code

- ☐ G9001 Initial Assessment _____
- ☐ G9006 Home Assessment _____
- ☐ G9011 Case Management Visit Outside the Home _____
- ☐ G9012 Case Management HOME Visit _____

County Codes

Estimated Date of Next Visit

Date Case Closed*

Case Management Services

- ☐ G9002 Case Management _____
- ☐ G9005 High Risk Case Management _____

Client lost to follow-up?
☐ Yes