



Care Coordinator Service Report Steps Ahead Maternity Care Program

Patient Information

Name (Last, First, MI)	SS#:
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Care Coordination

Psychosocial/Medical Risks: Was patient high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Medical <input type="checkbox"/> Psychosocial <input type="checkbox"/> Both			
Care Coordinator Encounters:			
	Date	CC Performing Encounter	Type of Encounter
First CC Encounter (T1016U1):	_____	_____	_____
Second CC Encounter (T1016U2):	_____	_____	_____
Pre-delivery Encounter (T1016U3):	_____	_____	_____
Postpartum Encounter (T1016U4):	_____	_____	_____
Total # of Encounters: _____			
Bill T1016U5 if all four encounters were performed at the same location.			
Describe any unsuccessful encounters: Date of Attempts & Type of Attempts (Phone Calls, Home Visit, Cert. Mail, Etc.) _____ _____ _____			
If the Postpartum encounter is prior to 4 weeks after delivery please explain the reason. _____ _____			

Post Delivery Information

Postpartum Medical Exam Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ If no, reason: <input type="checkbox"/> Scheduled <input type="checkbox"/> Scheduled, not kept <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> Moved out of District	PP Birth Control: (Identified through PP exam or through CC encounters) <input type="checkbox"/> Injection <input type="checkbox"/> Condoms/Spermicide <input type="checkbox"/> Sterilization <input type="checkbox"/> Implant <input type="checkbox"/> Pills <input type="checkbox"/> None <input type="checkbox"/> Other: _____
Neonatal Death (≤ 28 days): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where did it occur: <input type="checkbox"/> Home <input type="checkbox"/> Hospital Infant Death Form: (faxed to Child Death Review System)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, attach form.</i>	Referred for Home Visit: <input type="checkbox"/> Yes <input type="checkbox"/> No Care Coordination Records Forwarded to DHCP: <input type="checkbox"/> Yes <input type="checkbox"/> No Grievance/Complaint Filed: <input type="checkbox"/> Yes <input type="checkbox"/> No

Care Coordinator

Practice/Site

Date