



Care Coordinator Encounters Report

Recipient's Name: _____ SS#: _____ Medicaid #: _____

EDC: _____ DHCP: _____ Risk Status High Low

	Initial Encounter	Subsequent Encounter	Subsequent Encounter	Hospital PP Visit
Date of Encounter				
Type of Encounter	<input type="checkbox"/> Face to Face	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone	<input type="checkbox"/> Face to Face
GA at Encounter				N/A
Keeping Prenatal Appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	N/A
Medicaid Status	<input type="checkbox"/> Approved # _____ <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Approved # _____ <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Approved # _____ <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Approved # _____ <input type="checkbox"/> Pending <input type="checkbox"/> Denied
If Medicaid Pending or Denied	<input type="checkbox"/> Application <input type="checkbox"/> Reapplication Date: _____ Site: _____	<input type="checkbox"/> Application <input type="checkbox"/> Reapplication Date: _____ Site: _____	<input type="checkbox"/> Application <input type="checkbox"/> Reapplication Date: _____ Site: _____	<input type="checkbox"/> Application <input type="checkbox"/> Reapplication Date: _____ Site: _____
Discussed or Attended Prenatal Classes	<input type="checkbox"/> Interested <input type="checkbox"/> Enrolled <input type="checkbox"/> Not Interested <input type="checkbox"/> Undecided	<input type="checkbox"/> Interested <input type="checkbox"/> Enrolled <input type="checkbox"/> Not Interested <input type="checkbox"/> Undecided	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____	N/A
Discussed Birth Control / Plan First	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Control Method Chosen				
Is patient on WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If patient not on WIC, is WIC to be obtained for infant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
List Pediatric Provider/ Patient First Newborn Form	N/A	N/A	Name: _____ Fax: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: _____ Fax: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Visit Needed	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____
Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transportation				
Financial Support				
Housing Adequate				
Support System				
Family concerns				
Pregnancy Issues				
Prenatal Vitamins				
Baby Needs				
SIDS/Back to Sleep				
Breast/Bottle Feeding				
Shaken Baby Syndrome				
Other				

Initial Encounter

Specify identified medical/psychosocial risk/resolution:

Notes: (include any problems identified, follow-up on problems, updates)

Care Coordinator

Date

Site

Subsequent Encounter

Specify identified medical/psychosocial risk/resolution:

Notes: (include any problems identified, follow-up on problems, updates)

Care Coordinator

Date

Site

Subsequent Encounter

Labor & Delivery Discussed? Yes No

Pre-admission to Hospital Complete? Yes No

Transportation Assistance Needed? Yes No If yes, transportation to hospital provided by? _____

Specify identified medical/psychosocial risk/resolution:

Notes: (include any problems identified, follow-up on problems, updates) BECK SCORE IF DEPRESSED _____

Care Coordinator

Date

Site

Hospital Postpartum Visit

Infant Name: _____ Infant's Sex: Male Female Infant's Weight: _____

Date of Delivery: _____ Any delivery complications? Yes No

If yes, describe complication: _____

Postpartum exam: Scheduled/Date _____ Provider Name: _____

Discussed/Contacted DHR/Medicaid after delivery? Yes No Infant of SSI Mother/Form Sent to Medicaid? Yes No

Home Visit Yes No If yes, reason for home visit _____

Notes: (include any problems identified, follow-up on problems, updates) _____

Care Coordinator

Date

Site