

MIECHV Home Visit Encounter Form

◆ Home Visitor: _____

◆ Agency ID: _____

◆ Date of Visit: _____

◆ Prenatal Participant Visit Yes No

Participant ID#: _____

◆ Time spent on form: _____ (min.)

Completed for each scheduled home visit

◆ Caregiver First Name: _____		◆ Caregiver Last Name: _____			
Index children participating in visit: _____					
SCHEDULED HOME VISIT COMPLETION					
<input type="checkbox"/> ◆ Completed <input type="checkbox"/> ◆ Attempted <input type="checkbox"/> ◆ Cancelled	◆ Start time: _____ am pm		◆ Miles driven: _____ one-way		
	◆ Length of Visit: _____ minutes		Driving time: _____ minutes		
	◆ Location: <input type="checkbox"/> Family home <input type="checkbox"/> Relative's home <input type="checkbox"/> HV office/center <input type="checkbox"/> Other: _____				
Reason: <input type="checkbox"/> Participant not at home <input type="checkbox"/> Participant refused <input type="checkbox"/> Participant not available <input type="checkbox"/> Other: _____			Reschedule date: _____		
Family: <input type="checkbox"/> Illness <input type="checkbox"/> Schedule conflict <input type="checkbox"/> Other: _____ Home visitor: <input type="checkbox"/> Illness <input type="checkbox"/> Schedule conflict <input type="checkbox"/> Holiday/office closed			Reschedule date: _____		
Visit Activities	Planned	◆ Completed	Visit Activities	Planned	◆ Completed
Education	min.	<input type="checkbox"/> min.	Child & family goal setting	min.	<input type="checkbox"/> min.
Parent-child interaction	min.	<input type="checkbox"/> min.	Domestic violence/safety plan	min.	<input type="checkbox"/> min.
Screening	min.	<input type="checkbox"/> min.	Mental health support	min.	<input type="checkbox"/> min.
Assessment	min.	<input type="checkbox"/> min.	Referrals	min.	<input type="checkbox"/> min.
Other:	min.	<input type="checkbox"/> min.	Other:	min.	<input type="checkbox"/> min.
Specify Activity (describe): _____					
◆ TOPICS ADDRESSED (check all that apply)					
<u>Prenatal Care</u> <input type="checkbox"/> Breastfeeding ◆ <input type="checkbox"/> Family planning/inter-birth interval ◆ <input type="checkbox"/> Multi-vitamin use ◆ <input type="checkbox"/> Prenatal visit schedule ◆ <input type="checkbox"/> Fetal development <input type="checkbox"/> Postpartum care	<u>Child Development</u> <input type="checkbox"/> ASQ results ◆ <input type="checkbox"/> Communication <input type="checkbox"/> Fine Motor <input type="checkbox"/> Gross Motor <input type="checkbox"/> Problem Solving <input type="checkbox"/> Personal Social/Social Emotional <input type="checkbox"/> Transitions	<u>Parental Well-being & Stress</u> <input type="checkbox"/> Domestic violence ◆ <input type="checkbox"/> Safety plan ◆ <input type="checkbox"/> Smoking cessation ◆ <input type="checkbox"/> Community resources <input type="checkbox"/> Mental health <input type="checkbox"/> Substance abuse	<u>Family Development</u> <input type="checkbox"/> Child approaches to learning <input type="checkbox"/> Discipline, challenging behaviors <input type="checkbox"/> Parent-child interaction <input type="checkbox"/> Parenting <input type="checkbox"/> Play		
<u>Health & Safety</u> <input type="checkbox"/> Injury prevention ◆ <input type="checkbox"/> Well Child Exams ◆ <input type="checkbox"/> Child nutrition	<input type="checkbox"/> Child physical growth <input type="checkbox"/> Hearing <input type="checkbox"/> Immunizations <input type="checkbox"/> Safe sleep	<input type="checkbox"/> Signs/symptoms child illness <input type="checkbox"/> Oral health <input type="checkbox"/> Use of medical services <input type="checkbox"/> Vision	<u>Other Topics (describe)</u> _____		
Topic Materials Used (describe): _____					
◆ SCREENING & ASSESSMENTS COMPLETED (check all that apply)					
<input type="checkbox"/> Adult Health <input type="checkbox"/> ASQ-3 _____ mos. <input type="checkbox"/> ASQ-SE _____ mos.	<input type="checkbox"/> Child Health <input type="checkbox"/> Demographic <input type="checkbox"/> EPDS	<input type="checkbox"/> ESI <input type="checkbox"/> FSPOS <input type="checkbox"/> Goal Setting	<input type="checkbox"/> HOME <input type="checkbox"/> LSP <input type="checkbox"/> Maternal Health	<input type="checkbox"/> RAT <input type="checkbox"/> WAI-Initial <input type="checkbox"/> WAI-Final	<input type="checkbox"/> HOVRS A+ <input type="checkbox"/> Other: _____
HOME VISIT SUMMARY					
Child goals addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Family goals addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No			
◆ Referral Initiated: <input type="checkbox"/> Yes <input type="checkbox"/> None		◆ Referral Follow-Up: <input type="checkbox"/> Not applicable <input type="checkbox"/> Complete <input type="checkbox"/> Not Complete			
Materials left:			Family will:		
Home Visitor will:			Plan for next visit:		
Next Visit Date:		Time:	am pm	Location:	
Others involved in home visit (check all that apply): <input type="checkbox"/> Other children <input type="checkbox"/> Father of child <input type="checkbox"/> Mother of child <input type="checkbox"/> Grandparent <input type="checkbox"/> Friend <input type="checkbox"/> PSR staff <input type="checkbox"/> Child welfare staff <input type="checkbox"/> Infant/Toddler (Part C) staff <input type="checkbox"/> MIECHV staff <input type="checkbox"/> Other adult (specify relationship): _____					

◆ Required Information ◆

Home Visitor Signature: _____ Family Signature: _____

NOTES

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