FATHER/OTHER VISIT ENCOUNTER FORM

Date: (mm/dd/yyyy) _____ Staff:_____
Client's Name: _____ HSID: _ _ _ _ -_ _ _ _-_ _
Current Age:_____ Date of Birth (mm/dd/yyyy)_____
Location of visit: ☐ Home ☐Office ☐ Clinic☐ Hospital ☐Telephone ☐ Other,Specify_____
Length of Visit _____ Minutes
Participation Status:
☐Primary Adult Associated with child
☐ Accompanying Other Primary, explain_____
☐ Other: explain_____

Interventions Provided

☐ **Further Assessment/Screening** ☐ Specify_____

- ☐ Father/Other Enrollment Specify_____
- ☐ HS-FS Annual Assessment Year_____
- ☐ Domestic Violence Specify_____
- ☐ Substance Abuse Assessment Specify_____
- ☐ PHQ9 (Pop-out Assessment Tool) ☐ Score_____ ☐ Not Competed
- ☐ Protective factors Survey (Pop-out Assessment Tool). ☐ Not Competed
- ☐ PICCOLO: Affection_____ Responsiveness_____ Encouragement_____ Teaching_____
- ☐ Exit Specify_____
- ☐ Family Planning Status Specify_____
- ☐ Tobacco Use Specify_____
- ☐ Other Specify_____

☐ **Distribution of Car Seat,** Specify_____
☐ **Immunizations,** Specify_____
☐Distribution of Barrier Methods of Contraception Specify_____
☐ **Transport to Medical/Social Services Appointment** Specify_____
☐ **Other,** Specify_____

☐ **Clinical Evaluation:**
☐ Temp: Value:_____
☐ Pulse: Value:_____
☐ Respiration: Value:_____
☐ BP: Value:_____
☐ Weight: Lbs:_____
☐ Height: Value:_____
☐ Blood Glucose Value:_____
☐ Other Value:_____

☐ **Counseling/Education/Advising:**

☐ Alcohol/Drug Use
☐ Asthma
☐ Basic Needs
☐ Behavioral & Emotional Health
☐ Breastfeeding
☐ Complications
☐ Cultural/Spiritual Aspects of Health
☐ Community Resources (WIC, ect)
☐ Depression
☐ Diabetes
☐ Domestic Violence
☐ DV Safety Plan Developed
☐ Environmental Risks
☐ Exercise, Rest, Activity
☐ Family Planning Methods
☐ Follow-up Care/Tests & Procedures
☐ Health Insurance Coverage
☐ HIV/AIDS
☐ Homelessness
☐ Hygiene
☐ Hypertension
☐ Immunizations/Pertussis
☐ Medications
☐ Mammogram/Self Breast exam
☐ Nutrition
☐ Sexually Transmitted Infections
☐ Overweight/Obesity
☐ Pain Management
☐ Pap Smear
☐ Parenting Behavior
☐ Peridontal Infection/Dental Caries
☐ Reproductive Life Plan/Child Spacing
☐ Safety, Specify_____
☐ Second Hand Smoke
☐ Stress Management
☐ Social Health & Support
☐ Tobacco Use
☐ Underweight
☐ Vaping

Handouts Provided

☐ Literature regarding covered education topics
☐ Family Spirit participant Activity Sheets, Specify_____
☐ Other, Specify_____

☐ **Consult With,** Specify_____

☐ **Other,** Specify_____

Referrals

☐Referral to Specify_____
Purpose_____ Other/Specify:_____
All referrals should have a progess check within 45 days, please enter the date referral progress was checked on (mm/dd/yyyy)_____
Client Recieved Service ☐ Yes ☐ No ☐ Refused ☐ Don't know/lost to follow up
Info Source: ☐ Verified ☐ Self-Report

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Purpose____________________________ Other/Specify:_________________________________
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Family Spirit Modules:
First Lesson Covered

(PC) Prenatal Care	specify lesson ______________________________________
(MFM) My Family and Me	specify lesson ______________________________________
(HL) Healthy Living	specify lesson ______________________________________
IC) Infant Child	specify lesson ______________________________________
(YGC) Your Growing Child	specify lesson ______________________________________
(TC) Toddler Care	specify lesson ______________________________________

Second Lesson Covered

(PC) Prenatal Care	specify lesson ______________________________________
(MFM) My Family and Me	specify lesson ______________________________________
(HL) Healthy Living	specify lesson ______________________________________
IC) Infant Child	specify lesson ______________________________________
(YGC) Your Growing Child	specify lesson ______________________________________
(TC) Toddler Care	specify lesson ______________________________________

NOTES: