HEALTHY START- INFANT/CHILD ENCOUNTER FORM

Date: (mm/dd/yyyy) __________ Staff:____________________

Child'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

Interventions Provided

☐ **Further Assessment/Screening** ☐ Specify______________________

- ☐ Risk Identifier Infant Component & Infant Addendum, Specify____________________
- ☐ HS 1 Year Assessment Specify____________________
- ☐ HS 2 Year Assessment Specify____________________
- ☐ HS 3 Year Assessment Specify____________________
- ☐ HS 4 Year Assessment Specify____________________
- ☐ HS 5Year Assessment Specify____________________
- ☐ ASQ3 Age months:_______ (2,4,6,8,9,10,12,14,16,18,20,22,24,27,30,33,36,42,48,54,60)
  - Communiciation: _____________ Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No
  - Gross Motor Score: _____________ Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No
  - Fine Motor Score: _____________ Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No
  - Problem Solving Score:_____________ Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No
  - Personal-Social Score: _____________ Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No
  - ☐ Scores reviewed with parents ☐ Yes☐ No
- ☐ ASQ-SE Age months:_______ (2,6,12,18,24,30,36,48,60) Score________________

Score prompts referral? ☐ Yes ☐ Near Cut Off ☐ No Scores reviewed with parents? ☐ Yes. ☐ No

If any ASQ-3 or ASQ-SE score is in the referral range, but no referral was made, what is the reason?

- ☐ Known issue, already receiving special services
- ☐ Opted to wait and retest at next visit
- ☐ Declined referral
- ☐ No services to refer to
- ☐ Other, Specify___________________

☐ Lollipop Age mos:_______ (24,30,36,42,48,54,60)

Identification of Colors & Shapes : Score:____________ (Valid Range: 0-17)

Picture Discription & Spatial Recognition: Score:____________ (Valid Range: 0-17)

Identification of Numbers & Counting: Score:____________ (Valid Range: 0-17)

Identification of Letters & Writing: Score:____________ (Valid Range: 0-18)

Total Score:____________

Scores reviewed with parents? ☐ Yes ☐ No

☐ Exit

☐ Other, Specify__________________

☐ **Administration of Immunizations,** Specify____________________
☐ **Distribution of Car Seat,** Specify____________________
☐ **Distribution of Emergency Infant Supplies** Specify____________________
☐ **Transport to Medical/Social Services Appointment** Speicfy____________________
☐ **Other,** Specify____________________

☐ **Clinical Evaluation:**
- ☐ Temp: Value:________________
- ☐ Pulse: Value:________________
- ☐ Respiration: Value:________________
- ☐ BP: Value:________________
- ☐ Weight: Lbs:_______Ozs:______
- ☐ Length: Value:________________
- ☐ Head Circumference Value:________________
- ☐ Other Specify:_______________

☐ **Infant/Child Counseling/Education/Advising:**
- ☐ Asthma
- ☐ Attachment/Bonding
- ☐ Breastfeeding
- ☐ Bowel Habits
- ☐ Car Seats & Automibile Safety
- ☐ Childcare
- ☐ Community Resources (WIC, ect)
- ☐ Developmental Delays
- ☐ Early Child Caries
- ☐ Environmental Risks
- ☐ Failure to Thrive
- ☐ Family Violence/Intentional Injury
- ☐ Follow-Up/Well Child Care
- ☐ Growth & Development
- ☐ Health Insurance/Coverage
- ☐ HIV/AIDS
- ☐ Homelessness
- ☐ Hygiene
- ☐ Illness
- ☐ Immunizations
- ☐ Introduction to Solid Foods
- ☐ Neonatal Jaundice
- ☐ Nutrition and Feeding
- ☐ Other, Specify__________
- ☐ Other Special Health Care Needs
- ☐ Parenting and Behavior
- ☐ Prenatal Alcohol Exposure
- ☐Prenatal Drug Exposure
- ☐ Safe Sleep/SIDS Prevention
- ☐ Safety, Specify____________
- ☐ Second Hand Smoke
- ☐ Shaken Baby Prevention & Purple Crying
- ☐ Social/Emotional Development
- ☐ Toilet Training Readiness
- ☐ Weaning

Handouts Provided
- ☐ Literature regarding covered education topics
- ☐ Family Spirit participant Activity Sheets, Specify_____________________
- ☐ Healthy Start, Grow Smart Booklet
- ☐ 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

☐Referral to Specify________________________________
Purpose____________________________ Other/Specify:________________________________
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Info Source: ☐ Verified ☐ Self-Report

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 ______________________________________

Family Spirit Modules:
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 ________________________________

ASQ Activities Reviewed:

ASQ-3 Learning Activity Book Sheet 11:
Age level:____________ (months)
Domain:______________(Gross Motor, Fine Motor, Communication, Problem Solving, Personal Social)

ASQ-3 Learning Activity Book Sheet 2 :
Age level:____________ (months)
Domain:______________(Gross Motor, Fine Motor, Communication, Problem Solving, Personal Social)

ASQ-3 Learning Activity Book Sheet 3 :
Age level:____________ (months)
Domain:______________(Gross Motor, Fine Motor, Communication, Problem Solving, Personal Social)

ASQ-3 Activity Chart: Age Months:__________________________
ASQ-SE Activity Chart: Age Months:__________________________

Gikinawaabi for Ages 3-5 years
Gikinawaabi Lessons Presented (Lesson number 1-13)________________

Parent Child Activity Log: New at home activities logged by parent since last visit/review:

Number of Math Activities Logged ____________________ (Valid Range 0-50)
Number of Reading Activities Logged ____________________ (Valid Range 0-50)
Number of Writing/Drawing Activities Logged ____________________ (Valid Range 0-50)
Number of Playing Together Activities Logged ____________________ (Valid Range 0-50)

Notes Comments on Gikinawabi:

HEALTHY START-INFANT CHILD ENCOUNTER FORM

Date Medical Chart Record Started_______________ Staff______________________________

Status

Updated Date: ________________________ (Date of Current Visit)

Health Insurance Status: ☐ Medicaid ☐ MI-Child ☐Private ☐ None
Medical Home Status: ☐ Yes ☐ No
If Yes, Medical Home Description:
☐Tribal Clinic ☐Private Practice ☐Community Health Center ☐ Hospital Based Primary Care Center

Meets CSHCN criteria? ☐ Yes ☐ No

Recommended Infant/Child Well-Child Visit Schedule

Recommended Infant/Child Well-child Visit Schedule according to New AAP guidelines March 2019

*Please exclude children with special needs or who are at or in high risk medical situations. An alternative visit schedule may be needed

1. Based on the birthdate of the child, the system will auto populate the target dates for well-child visits.
2. Document which visits have already been completed for the infant/child and check "Completed box"

		Target Date	Check (x) if Completed	Date Visit Completed	Concerns Identified at Visit/Comments about Missed Visits
Infancy	Newborn/in hospital				
	3-5 Days post discharge				
	By 1 Month				
	2 Months				
	4 Months				
	6 Months				
	9 Months				
	12 Months				
	15 Months				
Early Childhood	18 Months				
	24 Months				
	30 Months				
	3 Years				
	4 Years				
	5 Years				
	Total Visits:				

Age: _________ months

ILLNESS/ ER/ HOSPITAL VISITS

DATE OF VISIT____________ REASON______________________________
TYPE OF VISIT:__________________________ Choose type below
Emergency room, Child Injury or Ingestion, Medical Care Visit, Hospital Admissions (All Causes)

NOTES: