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| **Infant Health Care Form:**(Please note: The Infant Health Care Forms is 4 pages) |

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| **Purpose:**The purpose of this form is to gather information on and the child’s general health; immunization status; developmental disability/concerns, chronic illnesses, and behavior problems; visits to emergency room/urgent care centers, and hospitalizations for injuries/ingestions; breastfeeding; and referrals to child welfare. This helps track child health and development outcomes for the children in the program.**General Guidelines:** * This form is completed at four points in time: Infancy 6 Months & 12 Months, Toddler 18 & 24 Months
* Explain to the client that she may have reported previously some of the information you will be asking her about, but that you would like to systematically review with her the child’s health and use of health services since the last time this form was completed (give date) to be sure that you have a complete history at this time.

**Definitions/Directions for Completing Form****Well child visits:*** Indicate all the well child visits that the child has completed since the previous data collection time point.
* Care should be taken to only select the visits attended since the last data collection time point to prevent any duplicate data entry

**Immunizations:*** Immunization information may be collected by mother's report. However. NHVs are strongly encouraged to check a written record.
* There is a question on the Infant Health Care form that asks whether the immunization information collected was from written record or mothers self-report.

**Infant's weight and height:*** The form asks for a percentile. Use the WHO (World Health Organization) growth charts:

<http://www.cdc.gov/growthcharts/who_charts.htm>**Does your child have any of the following:*** The information in this table informs the STAR Framework: Maternal Role Domain- Child Health and Development

**ER Visits and Hospitalizations:*** **Injury includes: Cut**/wound, burn, broken bone, concussion, etc.
* Use this classification also if client went to emergency room to have child checked because of a fall/accident, but was told he/she was okay.
* **Ingestion includes:** Swallowed coin/other small object or potentially harmful substance, such as medicine, cleaning fluids, etc.
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| **Client Name:** |

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| **Client ID:** |  | **Nurse ID:** |  | **Date:** |

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| **Check one:** | * Infancy 6 Months
 | * Infancy 12 Months
 | * Toddler 18 Months
 | * Toddler 24 Months
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| **“I would like to review your baby’s health and healthcare services”**1. Have you taken (child’s name) for a well-child check-up in the last 6 months? (**Note to Nurse Home Visitor:** Please only report well-child visits completed since the last time this form was completed)
* No
* Yes (If yes, please indicate which of these well child visits were completed; check all that apply)
* Within the first week since birth
* By 1 month old
* 2 months old
* 4 months old
* 6 months old
* 9 months old
* 12 months old
* 15 months old
* 18 months old
* 24 months old
* 24 month visit scheduled but not yet completed
1. Where do you usually take (child’s name) for any medical follow up? (single select)
* Family doctor
* Walk In Clinic
* Pediatrician
* Emergency room
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does not take child for health check ups; no identified need or did not know of need
* Declined or unable to answer
1. Based on your immunization schedule is (child’s name) up-to-date on all vaccinations:
* Yes
* No
* Not aware of schedule
* Declined or unable to answer
1. Was the above information on child’s immunization status based on written record or mother’s self-report?
* Written record (Child Health Passport)
* Mother’s self-report
1. What is the child’s current weight? (Based on last recorded weight) Date of last weight: \_\_\_\_\_\_\_\_\_

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| \_\_\_\_\_\_\_\_\_ kilograms  | \_\_\_\_\_\_\_\_\_ percentile | 🞎 Unable to provide |

1. What is the child’s current length? (Based on last recorded length) Date of last length: \_\_\_\_\_\_\_\_\_

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| \_\_\_\_\_\_\_\_\_ centimeters  | \_\_\_\_\_\_\_\_\_ percentile | 🞎 Unable to provide |
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| 1. Does your child have any of the following:

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| **Developmental Disability or Concerns*** Blindness
* Cerebral palsy
* Deafness
* Neurodevelopmental disorders

(e.g., cognitive delay)* Not meeting normal physical growth curve
* Not meeting or delayed developmental milestones
* Seizures
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **Chronic Illnesses*** Asthma
* Cancer
* Cystic fibrosis
* Diabetes
* HIV
* Sickle cell anemia
* Spina bifida
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **Behavior Problems*** Excessive crying
* Feeding problem
* Sleeping problem
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Injuries and Ingestions**1. **Emergency Room Visits : Injuries and Ingestions**

In the past 6 months, have you taken your child to a **hospital or other emergency room** for an **INJURY** or because you were concerned your child **swallowed** something harmful? **(INGESTION)** * Yes (**If yes to either INJURY or INGESTION, please mark the reason and number of times)**
* No

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| **INGESTION – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., swallowed coin) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **INJURY – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., burns, broke wrist) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| 1. **Walk-In Clinic** **Visits: Injuries and Ingestions**

In the past 6 months, have you taken your child to a **Walk-In Clinic** for an **INJURY** or because you were concerned your child **swallowed** something harmful? **(INGESTION)** * Yes (**If yes to either INJURY or INGESTION, please mark the reason and number of times)**
* No

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| **INGESTION – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., swallowed coin) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **INJURY – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., burns, broke wrist) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

1. **Hospital Admissions: Injuries and Ingestions**

In the past 6 months how many times **has your baby been admitted to hospital** (that is, had to spend at least one night there) for an **INJURY** or because you concerned your child **swallowed** something harmful? **(INGESTION)** * Yes (**If yes to either INJURY or INGESTION, please mark the reason and number of times)**
* No

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| **INGESTION – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., swallowed coin) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **INJURY – Number of times:** \_\_\_\_\_ |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., burns, broke wrist) |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Age of Child: \_\_\_\_\_ |  Description of situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Special Care Baby Unit**1. If (Child’s name) was in the neonatal unit, is he/ she still in the neonatal unit or special care nursery? (only completed at 6 month assessment).
* Yes
* No (specify) \_\_\_\_\_\_ number of days spent in neonatal unit/ special care nursery.
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| **Breastfeeding**1. Have you ever breastfed or expressed milk for your baby?
* Yes
* No (Skip to Question #11)
1. How are you currently feeding your baby?
* Exclusive breastfeeding
* Non-exclusive breastfeeding
* No breastfeeding
* Not assessed
1. At what age did you offer complementary foods to your baby? \_\_\_\_\_ months (decimal) (ask at 6 and 12 month only)
* Not yet offering complementary foods
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| **To be completed after the home visit by the NHV:**1. Are you aware of any referral regarding mother/ family to your Child Welfare/Protection Organizaiton for concerns regarding suspected abuse or neglect of child since his/her birth?
* Yes

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_* No
1. Did you (NHV) initiate any referral of mother/ family to Child Welfare/ProtectionOrganizaiton for concerns regarding suspected abuse or neglect of child since his/her birth?
* Yes

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_* No
1. Are you aware of any referral to your Child Welfare/Protection Organizaiton for voluntary support services since the baby’’s birth?
* Yes

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_* No
1. Did you (NHV) initiate any referral of mother/ family to the local Child Welfare/Protection Organizaiton for voluntary support services since his/her birth?
* Yes

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_* No
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