
CLIENT INFORMATION TAB

Client is a Caregiver/Adult:

Client Name: _____ Date of Activity: _____

(MM/DD/YYYY)

Client Address: _____ City: _____ Zip Code: _____

County of Residence: _____ Phone Number: _____

E-mail: _____

Primary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Secondary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Household Size: _____ Annual Household Income: \$ _____

Has the client had a well visit during the last 12 months? (With any provider, not just within the program)

- ☐ No
- ☐ Yes

Do you have a Medical Home?

- ☐ No
- ☐ Yes

Go to Visit Information Tab

VISIT INFORMATION TAB

CAREGIVER/ADULT ONLY:

Program:

- ☐ Teen Pregnancy Targeted Case Management (TPTCM)

Would you (and/or your partner) like to become pregnant in the next year?

- ☐ Yes
☐ No
☐ Unsure
☐ Okay either way
☐ Currently Pregnant

Do you have a child or children?

- ☐ No
☐ Yes - **Do you have someone to turn to for day-to-day support with parenting or raising children?**
☐ No
☐ Yes

Are you pregnant?

- ☐ No - Not pregnant - **In the past year, how often have you used:**

Alcohol? (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

- ☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

Tobacco, Nicotine, and/or Vaping Products?

- ☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons?

- ☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

Illegal Drugs? (Including marijuana)

- ☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
☐ Yes

☐ Yes, Pregnant - **How often have you used the following substances since you found out that you are pregnant:**

Alcohol (since learning of pregnancy)?

- ☐ I am using alcohol more
- ☐ My alcohol use is about the same
- ☐ I have reduced the amount or frequency of alcohol use
- ☐ I have stopped using alcohol
- ☐ I have never used alcohol

Tobacco, Nicotine, and/or Vaping Products (since learning of pregnancy)?

- ☐ I am using tobacco, nicotine, and/or vaping more
- ☐ My tobacco, nicotine, and/or vaping use is about the same
- ☐ I have reduced the amount or frequency of tobacco, nicotine, and/or vaping use
- ☐ I have stopped using tobacco, nicotine, and/or vaping products
- ☐ I have never used tobacco, nicotine, and/or vaping products

Prescription Drugs for Non-Medical Reasons (since learning of pregnancy)?

- ☐ I am using prescription drugs more
- ☐ My prescription drug use is about the same
- ☐ I have reduced the amount or frequency of prescription drug use
- ☐ I have stopped using prescription drugs
- ☐ I have never used prescription drugs

Illegal Drugs (since learning of pregnancy)?

- ☐ I am using illegal drugs more
- ☐ My illegal drug use is about the same
- ☐ I have reduced the amount or frequency of illegal drug use
- ☐ I have stopped using illegal drugs
- ☐ I have never used illegal drugs

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
- ☐ Yes

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest in doing things

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling down, depressed, or hopeless

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling nervous, anxious, or on edge

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Not being able to stop worrying

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Do you have someone to turn to for day-to-day support?

- ☐ No
- ☐ Yes

Go to BAM Tab

BaM TAB

Information and Completion Status

Provider / Clinic Name: _____ Expected Due Date: _____

BaM Consent Form Signed: _____ Initial Survey Completed: _____

Completion Survey Completed: _____ Birth Outcome Card Completed: _____

Social Determinants of Health Screener Completed: _____ ASSIST Form Completed: _____

Edinburgh Completed (Session 2): _____ Edinburgh Score (Session 2): _____

Edinburgh Completed (Session 6): _____ Edinburgh Score (Session 6): _____

Edinburgh Completed (Postpartum): _____ Edinburgh Score (Postpartum): _____

Individual follow-up provided based on BaM Risk Status Report:

☐ No

☐ Yes - Date of follow-up: _____

Indication for follow-up (select all)

- ☐ Barriers to attending prenatal appointments
- ☐ Denies desire to become pregnant in the next year
- ☐ Denies having scheduled baby's first check-up
- ☐ Denies plan to schedule postpartum check-up
- ☐ Has not attended first prenatal appointment
- ☐ Health condition
- ☐ High risk pregnancy
- ☐ History of premature birth, low birth weight, more than one miscarriage, or infant loss
- ☐ NICU stay for baby was required
- ☐ Positive EPDS screen
- ☐ Positive response to NIDA substance use Pre-Screen Questions
- ☐ Positive response to SDOH Screener

Notes regarding indication for follow up:

Completion Status:

- ☐ Completed 4 or more sessions (Collect Completion Survey and Birth Outcome)
- ☐ Completed <4 sessions prior to delivery/EDD (Do not collect Completion Survey or Birth Outcome)

Baby Delivered (Date): _____

Delivery Outcome:

- ☐ Live birth
- ☐ Live birth but neonatal death (less than 28 days)
- ☐ Stillbirth (equal to or greater than 20 weeks gestation)
- ☐ Miscarriage (less than 20 weeks gestation)

Postpartum visit provided? (by BaM/Cb staff or other associated program staff)

- ☐ No
- ☐ Yes - **Date of postpartum visit:** _____

Setting of Visit:

- ☐ Home
- ☐ Clinic
- ☐ School
- ☐ Hospital
- ☐ Other Community Setting
- ☐ Virtual

Incentive Selected: _____

Incentive Delivered (Date): _____ **Completion Date:** _____

Participation Location:

- ☐ Completed all sessions with one organization
- ☐ Completed some sessions with another organization

Session Attendance

Session 1: Prenatal Care:

Date of attendance at Session 1: _____

Location of attendance at Session 1:

- ☐ In-person
- ☐ Virtually

Session 1 Education Provided:

- ☐ Alcohol/Substance Abuse
- ☐ Count the Kicks
- ☐ Father Involvement
- ☐ Health Care Coverage/Medicaid Eligibility
- ☐ Lifestyle risk factors/prenatal exposures
- ☐ Maternal Warning Signs
- ☐ Medical Home
- ☐ Nutrition
- ☐ Oral Health
- ☐ Prenatal Care
- ☐ Preterm Labor
- ☐ Smoking Cessation/Second-hand exposure
- ☐ State/Local Resources

Session 2: Pregnancy Health:

Date of attendance at Session 2: _____

Location of attendance at Session 2:

- ☐ In-person
☐ Virtually

Session 2 Education Provided:

- ☐ Alcohol/substance abuse
☐ Behavioral Health (Other than Perinatal Mood Disorders)
☐ Child Development
☐ COVID-19
☐ Family Violence
☐ Father Involvement
☐ Injury prevention/safety
☐ Lifestyle risk factors/prenatal exposures
☐ Nutrition
☐ Parenting
☐ Perinatal Mood and Anxiety Disorders
☐ Smoking Cessation/Second-hand exposure
☐ State/Local Resources
☐ Weight Management
☐ Stress Management

Session 3: Labor and Delivery:

Date of attendance at Session 3: _____

Location of attendance at Session 3:

- ☐ In-person
☐ Virtually

Session 3 Education Provided:

- ☐ Count the Kicks
☐ COVID-19
☐ Father Involvement
☐ Labor/Childbirth
☐ Maternal Warning Signs
☐ Preterm Labor
☐ State/Local Resources

Session 4: Infant Feeding:

Date of attendance at Session 4: _____

Location of attendance at Session 4:

- ☐ In-person
☐ Virtually

Session 4 Education Provided:

- ☐ Breastfeeding
☐ COVID-19
☐ Father Involvement
☐ Nutrition
☐ State/Local Resources
☐ Infant Care/Safety

Session 5: Infant Care:

Date of attendance at Session 5: _____

Location of attendance at Session 5:

- ☐ In-person
☐ Virtually

Session 5 Education Provided:

- ☐ Car seat safety/installation
☐ Child Development
☐ COVID-19
☐ Father Involvement
☐ Infant Care
☐ Injury Prevention/Safety
☐ Medical Home
☐ Parenting
☐ Safe Sleep
☐ Smoking Cessation/Second-hand Exposure
☐ State/Local Resources
☐ Well Child/Adolescent

Session 6: Postpartum Care:

Date of attendance at Session 6: _____

Location of attendance at Session 6:

- ☐ In-person
☐ Virtually

Session 6 Education Provided:

- ☐ Alcohol/Substance Abuse
☐ COVID-19
☐ Father Involvement
☐ Healthcare Coverage/Medicaid Eligibility
☐ Immunizations
☐ Lifestyle risk factors/prenatal exposures
☐ Maternal Warning Signs
☐ Medical Home
☐ Nutrition
☐ Perinatal Mood and Anxiety Disorders
☐ Postpartum Care
☐ Preconception/Interconception
☐ Reproductive Health/Family Planning
☐ Smoking Cessation/Second-hand Exposure
☐ State/Local Resources
☐ Suicide Prevention
☐ Teen Pregnancy Prevention
☐ Weight Management
☐ Well Woman/Man

Session 7: Postpartum and Infant Care Support:

Date of attendance at Session 7: _____

Location of attendance at Session 7:

- ☐ In-person
☐ Virtually

Session 7 Education Provided:

- ☐ Breastfeeding
- ☐ Car Seat Safety/Installation
- ☐ Health Insurance/Medical Home
- ☐ Immunizations
- ☐ Infant Care/Hot Topics
- ☐ Infant Development/Milestones
- ☐ Maternal Warning Signs
- ☐ Mental Health
- ☐ Newborn Screening
- ☐ Oral Health
- ☐ Pediatric CPR
- ☐ Reproductive Health/Life Planning
- ☐ Safe Sleep
- ☐ State/Local Resources
- ☐ Other -

Other Support Education Provided: _____

Notes:

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END OF VISIT TAB

Were any referrals made for this visit: (select all that apply)

- ☐ No Referrals
- ☐ Behavior Health
- ☐ Breastfeeding
- ☐ Developmental Screening
- ☐ Depression
- ☐ Infant Care
- ☐ Medical Home
- ☐ Prenatal Care
- ☐ Postpartum Care
- ☐ Substance Use
- ☐ Transition
- ☐ Well Visit

Were any health risk screening tools administered at this visit: (select all that apply)

- ☐ No Screening Tools
- ☐ ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)
- ☐ CRAFFT-N (Substance use screening for adolescents)
- ☐ EPDS (Edinburgh Postnatal Depression Scale)
- ☐ GAD-7 (Generalized Anxiety Disorder screening)
- ☐ PHQ-A Patient Health Questionnaire for Adolescents (depression)
- ☐ PHQ-9 Patient Health Questionnaire (depression)
- ☐ SDOH (Social Determinants of Health assessment)
- ☐ Other – **Specify other screening tool:** _____

Please complete the indicated risk screening tools.