TPTCM Encounter Form

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

TPTCM Encounter Form

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
- ○ Morer than half the days
- ○ Nearly every day

Feeling down, depressed, or hopeless

- ○ Not at all
- ○ Several days
- ○ Morer than half the days
- ○ Nearly every day

Feeling nervous, anxious, or on edge

- ○ Not at all
- ○ Several days
- ○ Morer than half the days
- ○ Nearly every day

Not being able to stop worrying

- ○ Not at all
- ○ Several days
- ○ Morer than half the days
- ○ Nearly every day

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

- ○ No
- ○ Yes

Go to TPTCM Tab

TPTCM Encounter Form

TPTCM TAB

Client is Pregnant (Prenatal Visit)

New Enrollee? (Select one)
- ○ Yes
- ○ No

What is your Due Date:_____

Initiated Prenatal Care (PNC): (Select one)
- ○ 1st Trimester
- ○ 2nd Trimester
- ○ 3rd Trimester
- ○ No PNC initiated

Complied with recommended PNC appointments after initiating care? (Select one)
- ○ Yes
- ○ No

During this pregnancy, were you screened for (select all that apply)
- ○ Depression
- ○ Anxiety
- ○ Substance Use
- ○ Not Screened

Education Provided (Complete only if education was provided):
- ○ Prenatal/Perinatal/Postpartum
  - ○ Prenatal Care
  - ○ Perinatal Health
  - ○ Postpartum Care
  - ○ Preconception/Interconception
  - ○ Preterm Labor
  - ○ Count the Kicks
- ○ Parenting/Childcare/Safety
  - ○ Parenting
  - ○ Father Involvement
  - ○ Infant Care
  - ○ Child Development/Developmental Screening
  - ○ Child Care Resources
  - ○ Safe Sleep
  - ○ Car seat safety/installation
  - ○ Injury prevention/safety
  - ○ Lead Prevention
- ○ Health/Lifestyle/Nutrition
  - ○ Nutrition
  - ○ Weight Management
  - ○ Lifestyle risk factors/prenatal exposures
  - ○ Smoking Cessation/Second-hand exposure
  - ○ Breastfeeding
  - ○ Oral Health

- ○ Mental Health/Behavioral Health
  - ○ Mental /Behavioral Health (Other than Perinatal Mood Disorders)
  - ○ Perinatal Mood and Anxiety Disorders
  - ○ Alcohol/Drugs Abuse
  - ○ Suicide Prevention
- ○ Healthcare Access/System Navigation
  - ○ Health Care Coverage/Medicaid Eligibility
  - ○ Health Care System Navigation
  - ○ Health Care Transition
  - ○ Medical Home
- ○ Resources/Assistance
  - ○ WIC
  - ○ Food Assistance
  - ○ Utilities Assistance
  - ○ Transportation Assistance
  - ○ State/local resources
  - ○ Adoption Counseling/Services
  - ○ Continuation of Education
- ○ Preventive/Well-Care
  - ○ Well Adolescent
  - ○ Well Child
  - ○ Well Woman
  - ○ Immunizations
  - ○ Special Health Care Needs
- ○ Reproductive Health/Family Planning
- ○ Other **Specify other education provided:** _____

During the program, client enrolled in: (Select one)

- ○ High School
- ○ GED Program
- ○ Vocation/Technical Schhol
- ○ Community College
- ○ 4-year College or University
- ○ None

Was there a second pregnancy after enrollment in program: (Select one)

- ○ No
- ○ Yes -**Date of pregnancy reported:**_____

Did the client complete basic education or vocational goals prior to 2nd pregnancy?

- ○ No
- ○ Yes

Client left the program for the following reasons: (Select one)

- ○ Still participating in program
- ○ Completed Goals
- ○ Client Terminated Participation
- ○ Miscarriage
- ○ Infant age 12 months
- ○ Client left/moved service area
- ○ Client cannot be located
- ○ Other - **Specify other reason:**_____

Exit Date: _____

Comments/Notes:

Go to End of Visit Tab

TPTCM TAB

Client is NOT Pregnant (Postnatal Visit)

New Enrollee? (Select one)
- ◯ Yes
- ◯ No

Date of infant's birth: _____

Have you attended your postpartum visit?
- ◯ No
- ◯ Yes - **Date of Postpartum Visit:_____**
- ◯ Scheduled - **Date of Postpartum Visit:_____**

Were you screened for the following during the pregnancy? (select all that apply)
- ☐ Depression
- ☐ Anxiety
- ☐ Substance Use
- ☐ Not Screened

Current Infant Feeding Method:
- ◯ Formula
- ◯ Breastmilk (breastfeeding/pumping)
- ◯ Both

Did you initiate breastfeeding at birth?
- ◯ No
- ◯ Yes - **How long did you exclusively breastfeed?**
  - ◯ < 1 month
  - ◯ 1 month
  - ◯ 2 months
  - ◯ 3 months
  - ◯ 4 months
  - ◯ 5 months
  - ◯ 6 months
  - ◯ 7 months
  - ◯ 8 months
  - ◯ 9 months
  - ◯ 10 months
  - ◯ 11 months
  - ◯ 12 months
  - ◯ >12 months

Gestational age of infant at birth (in weeks) (Select one)
- ◯ <32 weeks
- ◯ 32-27 weeks
- ◯ >37 weeks

What type of birth did you have:
- ◯ Vaginal
- ◯ Cesarean
- ◯ Vaginal Birth After Cesarean (VBAC)

Multiple Birth?(twins/triplets)
- ◯ No
- ◯ Yes

Infant received one-week visit to pediatrician/doctor? (Select one)
- ◯ No
- ◯ Yes

Infant placed for adoption? (Select one)
- ◯ No
- ◯ Yes - **Date of adoptive placement: _____**

Age of mother at time of adoptive placement: _____

Fetal/infant death? (Select one)
- ◯ No
- ◯ Yes - **Date of death: _____**

Age/Time of death? (Select one)
- ◯ Miscarriage
- ◯ Fetal death/stillborn
- ◯ <7 days
- ◯ 7-27 days
- ◯ 28-364 days

Education Provided (Complete only if education was provided):
- ☐ Prenatal/Perinatal/Postpartum
  - ☐ Prenatal Care
  - ☐ Perinatal Health
  - ☐ Postpartum Care
  - ☐ Preconception/Interconception
  - ☐ Preterm Labor
  - ☐ Count the Kicks
- ☐ Parenting/Childcare/Safety
  - ☐ Parenting
  - ☐ Father Involvement
  - ☐ Infant Care
  - ☐ Child Development/Developmental Screening
  - ☐ Child Care Resources
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  - ☐ Car seat safety/installation
  - ☐ Injury prevention/safety
  - ☐ Lead Prevention
- ☐ Health/Lifestyle/Nutrition
  - ☐ Nutrition
  - ☐ Weight Management
  - ☐ Lifestyle risk factors/prenatal exposures
  - ☐ Smoking Cessation/Second-hand exposure
  - ☐ Breastfeeding
  - ☐ Oral Health
- ☐ Mental Health/Behavioral Health
  - ☐ Mental /Behavioral Health (Other than Perinatal Mood Disorders)
  - ☐ Perinatal Mood and Anxiety Disorders
  - ☐ Alcohol/Drugs Abuse
  - ☐ Suicide Prevention

- ☐ Healthcare Access/System Navigation
  - ☐ Health Care Coverage/Medicaid Eligibility
  - ☐ Health Care System Navigation
  - ☐ Health Care Transition
  - ☐ Medical Home
- ☐ Resources/Assistance
  - ☐ WIC
  - ☐ Food Assistance
  - ☐ Utilities Assistance
  - ☐ Transportation Assistance
  - ☐ State/local resources
  - ☐ Adoption Counseling/Services
  - ☐ Continuation of Education
- ☐ Preventive/Well-Care
  - ☐ Well Adolescent
  - ☐ Well Child
  - ☐ Well Woman
  - ☐ Immunizations
  - ☐ Special Health Care Needs
- ☐ Reproductive Health/Family Planning
- ☐ Other **Specify other education provided: _____**

Was there a second pregnancy after enrollment in program: (Select one)

- ○ No
- ○ Yes -**Date of pregnancy reported:_____**

Did the client complete basic education or vocational goals prior to 2nd pregnancy?

- ○ No
- ○ Yes

Client left the program for the following reasons: (Select one)

- ○ Still participating in program
- ○ Completed Goals
- ○ Client Terminated Participation
- ○ Miscarriage
- ○ Infant age 12 months
- ○ Client left/moved service area
- ○ Client cannot be located
- ○ Other - **Specify other reason:_____**

Exit Date: _____

Comments/Notes:

Go to End of Visit Tab

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.