# Home Visit Encounter

Nurse-Family Partnership
Helping First-Time Parents Succeed

Client ID ____ Client Name ____ DOB ____

Date ____ ♦Time From ____ am/pm To ____ am/pm

Total Miles ____ Nurse Home Visitor ID ____ Nurse Home Visitor Name ____

♦**VISIT:** ☐ Completed ☐ Attempted ☐ Client cancelled visit ☐ Nurse home visitor cancelled visit

♦**TODAY'S VISIT SCHEDULE** ☐ Standard Visit Schedule ☐ Alternate Visit Schedule

♦**LOCATION OF VISIT:**
☐ Client's Home ☐ Family/Friend's Home ☐ Doctor/Clinic ☐ School ☐ Employment ☐ Public/Private Agency ☐ Other

♦**WHO WAS PRESENT AT THE VISIT:**
☐ Client ☐ Child ☐ Client's Mother ☐ Father of Child (FoC) ☐ Friend (s) ☐ Current Husband/ Partner not FoC ☐ Other Family Member ☐ NFP Supervisor ☐ Child Welfare Services ☐ 2nd NFP Professional ☐ Interpreter ☐ Other Professional ☐ Other_____

**PARTICIPANTS ENGAGED IN VISIT (rate 1 = low to 5 = high):**

| | Client | Client's Mother | Husband/Partner/FOC |
|---|---|---|---|
| Involvement | | | |
| Conflict with material | | | |
| Understanding of material | | | |

♦**PERCENT OF TIME SPENT ON EACH PROGRAM AREA:** **TIME SPENT**

My Health (Personal Health - Health Maintenance Practices; Nutrition and Exercise; Substance Use; Mental Health) ____ %

My Home (Environmental Health - Home; Work; School and Neighborhood) ____ %

My Life (Life Course - Family Planning; Education and Livelihood) ____ %

My Child/ Taking Care of My Child (Maternal Role - Mothering Role; Physical Care; Behavioral and Emotional Care of Child) ____ %

My Family & Friends (Personal Network Relationships; Assistance with Childcare) ____ %

**TOTAL** ____ **100%**

♦**PERCENT OF TIME SPENT ON PLAN:** ____ %

1. ♦ Do you have any concerns regarding your child's development, behavior or learning?
   ☐ Yes ☐ No ☐ Not Indicated at this visit ☐ N/A (still pregnant)

2. ♦Since our last visit, have you received any of the recommended prenatal or postpartum visits?
   ☐ Yes (if yes, please indicate which of these visits were completed; check all that apply)
   ☐ 6-9 weeks ☐ 10-13 weeks ☐ 14-17 weeks ☐ 18-21 weeks ☐ 22-25 weeks ☐ 26-29 weeks ☐ 30-32 weeks ☐ 33-35 weeks ☐ 36 weeks ☐ 37 weeks ☐ 38 weeks ☐ 39 weeks ☐ 40 weeks ☐ 41 weeks ☐ 1-8 week postpartum
   ☐ No ☐ N/A

3. ♦Since our last visit, has your child had any of the following well-child visits? (check all that apply)
   ☐ Yes (if yes, please indicate which of these well child visits were completed; check all that apply)
   ☐ In the nursery ☐ 3-5 days after 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
   ☐ No ☐ N/A

4. ♦Since our last visit, have you had continuous health insurance coverage?
   ☐ Yes ☐ No


*Revised October 2016*

5. Based on the client's need, what is the next planned visit schedule?
   - ☐ Standard Visit Schedule
   - ☐ Next visit not scheduled at this time
   - ☐ Alternate Visit Schedule Increased
   - ☐ Alternate Visit Schedule Decreased

**ER Visits and Hospitalizations**

6. ♦ Since our last visit, have you taken your child to the hospital emergency room/urgent care center for an injury or because you were concerned your child swallowed something harmful?

   ☐ Yes (If yes, please mark the reason and note the date)

   ***NOTE: ER and Urgent Care visits for illness should not be noted***

   ☐ Injury
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care

   ☐ Ingestion
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care
   - Date: ____/____/____ (month/day/year) ☐ Treatment Needed
     - ☐ Emergency Room ☐ Urgent Care

   ☐ No ☐ N/A (still pregnant)

7. ♦ Since our last visit, have you **taken** your child to the hospital emergency room/urgent care center for any other reason (excluding injury and ingestion)?

   ☐ Yes (If yes, please note the reason and date)
   - Reason: _____ Date: ____/____/____ (month/day/year)
     - ☐ Emergency Room ☐ Urgent Care
   - Reason: _____ Date: ____/____/____ (month/day/year)
     - ☐ Emergency Room ☐ Urgent Care
   - Reason: _____ Date: ____/____/____ (month/day/year)
     - ☐ Emergency Room ☐ Urgent Care

   ☐ No ☐ N/A (still pregnant)

8. ♦ Since our last visit, has your child been **admitted** to the hospital (that is, had to **spend at least one night** there) for an **injury** or because you were concerned your **child swallowed something** harmful?

   ☐ Yes (If yes, please mark the reason and note the admission date and length of stay for each admission)

   ***NOTE: Hospital stays for illness should not be noted***

   ☐ Injury
   - Date: ____/____/____ (month/day/year) ☐ **days**
   - Date: ____/____/____ (month/day/year) ☐ **days**
   - Date: ____/____/____ (month/day/year) ☐ **days**

   ☐ Ingestion
   - Date: ____/____/____ (month/day/year) ☐ **days**
   - Date: ____/____/____ (month/day/year) ☐ **days**
   - Date: ____/____/____ (month/day/year) ☐ **days**

   ☐ No ☐ N/A (still pregnant)

**Client screened for needed services** ☐ **Yes** ☐ **No** ☐ **No referral needed**

Please complete the Referrals to Services form if any referrals were made at this visit.



*Revised October 2016*