Infant Health Care

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Infant ID | Infant Name | Infant DOB

Infant SSN

Client ID | Client Name | DOB

Date | Nurse Home Visitor ID | Nurse Home Visitor Name

Check one: ☐ Infancy 6 Months ☐ Infancy 12 Months ☐ Toddler 18 Months ☐ Toddler 24 Months

1. ♦During a typical week, how many days do you (and/or a family member) read, tell stories, and/or sing songs to your child?
   - ☐ 0
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5
   - ☐ 6
   - ☐ 7

2. ♦Where do you usually take (child's name) for routine check-ups (well-child care)?
   - ☐ Health department
   - ☐ Community clinic
   - ☐ Hospital ER
   - ☐ Hospital clinic
   - ☐ Hospital Outpatient
   - ☐ Dr/Nurse Practioner's Office (Private doctor's office)
   - ☐ FQHC
   - ☐ Retail store/minute clinic
   - ☐ Other
   - ☐ None

3. ♦At time of visit, based on your local immunization schedule (regardless of vaccine brand or manufacturer) is (child's name) up to date on all vaccinations?
   - ☐ Yes (If yes, please indicate which of the immunizations were completed)
     - ☐ Completed all immunizations due for 0-5 months *(enter on 6 month form)*
     - ☐ Completed all immunizations due for 0-11 months *(enter on 12 month form)*
     - ☐ Completed all immunizations due for 0-17 months *(enter on 18 month form)*
     - ☐ Completed all immunizations due for 0-23 months *(enter on 24 month form)*
     - ☐ Completed all immunizations due for 24 months *(enter on 24 month form)*
     - ☐ 24 month immunizations not completed yet but scheduled with health care provider *(enter on 24 month form)*
   - ☐ No
     - ☐ Immunizations were refused
   - ☐ Unknown

4. ♦Is the information on child's immunization status based on written record or mother's self-report?
   - ☐ Written record
   - ☐ Mother's self-report

5. ♦Does your child have a usual source of dental care?
   - ☐ Yes
   - ☐ No

6. ♦Has (child's name) had a blood test for lead poisoning? If yes, ask about result of test.
   - ☐ No
   - ☐ Yes - result was negative
   - ☐ Yes - result was positive
   - ☐ Don't know

7. ♦What is the child's current weight? (Please weigh child.)
   ☐ lbs. ☐ oz. _____%
   - ☐ Client Report
   - ☐ Nurse Home Visitor Measurement

8. ♦What is the child's current height? (Measure child head to toe.)
   ☐ inches _____%
   - ☐ Client Report
   - ☐ Nurse Home Visitor Measurement

9. ♦What is the child's current head circumference? (Measure head circumference)
   ☐ centimeters
   - ☐ Client Report
   - ☐ Nurse Home Visitor Measurement

Breastfeeding:

10. ♦Has your child ever had breast milk?
    - ☐ Yes
    - ☐ No (Skip to 15)

11. Does your child continue to get breast milk?
    - ☐ Yes (Skip to 13)
    - ☐ No

12. How old was your child when s/he stopped getting breast milk?
    - ☐ Less than one week (Skip to 15)
    - ☐ One week or more; specify number of weeks: ☐ weeks (Skip to 15)

13. Is your child still exclusively receiving breast milk?
    - ☐ Yes (Skip to 15)
    - ☐ No

14. Until what age was your child fed exclusively breast milk (no water, juice, formula, cereal or other solids)?
    ☐ weeks

Safe Sleep:

15. ♦How often do you place your infant to sleep on their back?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

16. ♦How often do you bed-share with your infant?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

17. ♦How often does your infant sleep with soft bedding?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

18. ♦Does your child have health insurance coverage?
    - ☐ Yes (If yes, which type of health insurance do you use when you take your child for medical care; please check all that apply)
      - ☐ Medicaid
      - ☐ CHIP
      - ☐ Tri-Care
      - ☐ Private
      - ☐ Other (please specify)_____
    - ☐ No

To be completed by the Nurse Home Visitor:

Developmental Delay

19. Please provide Ages and Stages scores for the child:
ASQ:SE Version used: ☐ ASQ:SE ☐ ASQ:SE2

ASQ:SE Questionnaire used:	**6 months**	**12 months**	**18 months**	**24 months**
ASQ:SE Total				

☐ Child not eligible for screening at this time because child is receiving services
☐ Parent declined further screening

Squires, J., Twombly, E., Bricker, D. & Potter, L. (2009). ASQ-3 User's Guide 3rd Ed. Baltimore, MD: Paul H. Brookes Publishing Co, Inc.

Please complete the following after the home visit:

20. ♦Are you aware of any referral of mother/family to social services for child abuse, neglect or other reasons since the child's birth?
☐ Yes Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
☐ No

21. ♦Did you (nurse home visitor) initiate referral of mother/family to social services for child abuse, neglect or other reasons since the child's birth?
☐ Yes Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
Date of Referral: ____/____/____ (month/day/year)
☐ Abuse ☐ Neglect ☐ Other _____(please specify reason)
☐ No

H.O.M.E. Inventory (to be completed at Infancy 6 months and Toddler 18 months ONLY)

The H.O.M.E Inventory is optional and NOT required by NFP. Some agencies are required by their state to complete the H.O.M.E. to fulfill state funding requirements.

22. ♦Please provide the Infant/Toddler H.O.M.E. Inventory scores below:

	6 months	18 months
Parental Responsivity		
Acceptance of Child		
Organization of the Environment		
Learning Materials		
Parental Involvement		
Variety in Experience		
TOTAL SCORE		

Caldwell, B. M., & Bradley, R. H. (2003). Home Observation for Measurement of the Environment Inventory: Administration Manual. Little Rock, AR.