

CARING CONNECTIONS
Five Month Visit Form
OTTER TAIL COUNTY FAMILY
SERVICES COLLABORATIVE
UNIVERSAL HOME VISITING PROGRAM

(rev. 6/02)

Client ID # _____
FOR USE BY PUBLIC HEALTH ONLY

Child's Name: _____ DOB: _____ Date of Visit: _____

Home Visitor: _____ Agency: _____

If this visit was not made during the fifth month, please indicate reason for delay:

CHANGE IN FAMILY INFORMATION (if any):

Change of Address: _____

Change of Phone #/Contact Information: _____

Change in living arrangement for parents: Married Separated Divorced Deceased
(circle one)

MEDICAL/HEALTH RELATED INFORMATION:

Has your child received his/her: 2-month check-up by his/her doctor? Yes / No
4-month check-up by his/her doctor? Yes / No

Has parent scheduled 6-month check-up? Yes / No (circle one)
(Check-up should include shots and well-baby examine. NOTE: Shots are also given monthly at OTC Public Health Immunization Clinic. Contact OTC Public Health at 218-739-2528-FF or 218-385-3175-NYM for more information.)

Did child have normal growth rate at the time of last doctor visit? ____ Yes ____ No
(Include Height _____ Weight _____, if known)

What does child's diet consist of?
____ Breast Milk _____ Water
____ Formula _____ Juice
____ Breast & Formula Combined _____ Solids

General Health Concerns or Questions Noted by Doctor/Parent since time of last visit:

Is your child currently covered by health insurance? ____ Yes ____ No

PARENT/CHILDCARE INFORMATION:

Is Mother currently employed outside the home? Y/ N Father currently employed
outside the home? Y/ N Note: _____

Is child currently enrolled in daycare? Y/ N If so, approximately how
many hours per week? _____ Note: _____

Discuss Child Care Arrangements/Child Care Qualification/Suggestions (referral to
Child Care Resource and Referral, if necessary.
Notes:

Date: _____ Signature of Home Visitor

Child Name: _____

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Home Visitor checklist for Five Month Visit:
(Please check each item discussed at visit)

X

Discuss Childhood Development appropriate for 5 mos. - 1 year (see notes on visit guidelines). Encourage use of texture toy (gift) and other age-appropriate toys and activities for baby.

Notes: _____

Discuss Home Safety Information (as appropriate for age 5 mos. - 1 year):
Notes: _____

Provide appropriate referral for infant and older siblings, depending on family needs, including local ECFE offerings, PH, ECSE or Head Start.

Notes: _____

Discuss parent concerns and resources available for:

___ Physical/Emotion Health Concerns ___ Family Crisis Issues
___ Family Planning Concerns ___ Depression Issues
Note: _____

Discuss Local Family Recreation Areas - (Parks, libraries, etc.)

Provide Parent/General Resources and other information, as requested.
Notes: _____

Location of Visit: Single Family Home/Relative Home/Public Health Office/Other: _____
(please specify)

List all persons present during this home visit (please check all that apply): ___ Father
___ Mother ___ # of Siblings ___ grandparent(s) Others: _____

What is the preference on time for future home visits: _____ a.m. _____ p.m.

Approximate date for scheduling 12-month visit: _____

Date: _____
Signature of Home Visitor

FOR COMPLETION BY HOME VISITOR: Please complete and return within 10 days of visit.
Preparation Time: _____
Travel time to/from visit: _____
Mileage incurred to/from visit: _____
Time spent at visit: _____
Next visit scheduled: _____
Return completed form to:
Jane Patrick, Coordinator
Caring Connections
P.O. Box 394
Fergus Falls, MN 56538

FOR COMPLETION BY COORDINATOR ONLY:
Agency: _____ Date Submitted _____ Request NO. _____