CARING CONNECTIONS

(rev. 9/06)

DECLINED VISIT FORM

OTTER TAIL COUNTY FAMILY
SERVICES COLLABORATIVE
UNIVERSAL HOME VISITING PROGRAM

Client ID #__________________

FOR USE BY PUBLIC HEALTH ONLY

PLEASE COMPLETE THIS SECTION FOR EACH NEW FAMILY THAT REFUSES A POST-PARTUM VISIT:

(Note: It is very important that we receive all of this information each time a visit is declined.)

Visit Refused by: _____ Mother _______ Father _______ "No-Show" _________________ Other
(please check one)

School District __________________________________ Date Visit Offered:___________________

By Whom Offered:________________________________ Reason:__________________ Multip Y/N
(name of home visitor) Declined

Has this family given verbal permission to be offered future home visits? ___Y/ N___

If yes, please complete name, address and telephone number below.

PLEASE COMPLETE THIS SECTION WHEN A FAMILY HAS DECLINED THE POST-PARTUM VISIT, BUT WISHES TO BE OFFERED FUTURE VISITS OR HAS COMPLETED THE POST-PARTUM VISIT, BUT REFUSES ANY OR ALL OF THE SUBSEQUENT VISITS.

Child's Name:____ DOB:___________

Parent(s) Name:____

Address: ____

Telephone:___________________________________ Date Visit Offered:________________________

Assigned on-going home visitor: ____

Visit(s) Refused by: _____ Mother _____ Father _____ "No-Show" ________________ Other

Visits Refused: _______All Visits (_____2-6 weeks) (_____5 month)(_____12 month)

Please state reason given for declining visit(s)(if any):_______________

____

Notes:____

Date: _________________ ____
Signature of Home Visitor

FOR COMPLETION BY HOME VISITOR:
Time spent arranging/attempting visit:____________
Travel time to/from visit:_________________________
Mileage incurred to/from visit:___________________
Other:____
____

Return completed form to:
Jane Patrick, Coordinator
Caring Connections
P.O. Box 394
Fergus Falls, MN 56538