

**CARING CONNECTIONS  
INITIAL HOME VISIT FORM**

(rev. 5/05)

Client ID # \_\_\_\_\_

FOR USE BY PUBLIC HEALTH ONLY

**CHILD**  
**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** M F **RACE:** \_\_\_\_\_  
First MI. Last

**ADDRESS:** \_\_\_\_\_ **Home Telephone:** \_\_\_\_\_  
 \_\_\_\_\_ **Work:** \_\_\_\_\_  
 \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**RESIDENT SCHOOL DISTRICT:** \_\_\_\_\_

**DIRECTIONS TO HOME:** \_\_\_\_\_

<b>FAMILY/HOUSEHOLD MEMBERS</b>	<b>RACE</b>	<b>DOB</b>	<b>Social Security #</b>
<b>Mother:</b> _____ <small>First Last</small>	_____	_____	_____
<b>Father/</b> _____ <small>(Significant Other) First Last</small>	_____	_____	_____
<b>Siblings:</b> _____	_____	_____	<u>SEX</u> M F
_____	_____	_____	M F
_____	_____	_____	M F
<b>Other:</b> _____	_____	_____	M F
<b>Marital Status of Parents:</b> <u>Single</u> <u>Married</u> <u>Divorced</u> <u>Separated</u> <u>Widowed</u> <small>(circle one)</small>			
<b>Primary Language Spoken in Home:</b> <u>English/ Spanish/Other:</u> _____			
<b>Others offering support to family:</b> <small>(relatives, friends)</small> _____			

**PRIMARY HEALTH INFORMATION:**

**Birth Weight:** \_\_\_\_\_ **Pre-term Delivery:** Yes No **Feeding Type:** Breast Bottle

**Health or Developmental Concerns:**

<b>Is this child covered by health insurance:</b> Yes No	<b>If yes, name of insurance company:</b>
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Date: \_\_\_\_\_ Signature of Home Visitor \_\_\_\_\_

Child Name: \_\_\_\_\_

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**Home Visitor checklist for Post-Partum Visit:** (Please check each item discussed at post-partum visit)

**X**

**Introduction of Caring Connections Program**

Is this family eligible to receive on-going home visits?      Yes      No  
If yes, name of assigned on-going visitor:

Notes: \_\_\_\_\_ ECFE    HS    ECSE    PH  
(Agency - Circle One)

Provide general/parenting information and support/distribute materials as requested by parent(s):  
Notes:

Check Child Growth-Development/Language Development (discuss age-appropriate language development):  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Notes:

Discuss scheduled immunizations/well-child check-ups:  
Notes:

Provide appropriate referral depending on family needs: (ECFE, ECSE, WIC, Head Start)  
Notes:

Discuss Child Care Arrangements (referral to CCR&R, if necessary):

Provide Car Seat/Home Safety Information:  
Notes:

**IMPORTANT:** Please complete this information for data tracking purposes

Location of Visit: Single Family Home/Relative Home/Public Health/Other: \_\_\_\_\_  
(circle one)

Referred by: \_\_\_\_\_ Hospital \_\_\_\_\_ Advertisement \_\_\_\_\_ Other  
(Please specify hospital name or ad source)

List all persons present during this home visit (please check all that apply): \_\_\_\_\_ Father

\_\_\_\_\_ Mother \_\_\_\_\_ # of Siblings \_\_\_\_\_ grandparent(s) Others: \_\_\_\_\_

Was this family offered a post-partum visit by an Otter Tail County Public Health Nurse within 1-2 weeks of the date child was born? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, please circle reason for delay:

- 1) Delayed referral      2) Infant health/hospitalization      3) Difficulty scheduling
- 4) Parent request      5) Other : \_\_\_\_\_  
(please specify)

Date/time for next scheduled visit: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Notes/Comments/Concerns: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Home Visitor

**FOR COMPLETION BY HOME VISITOR:** Please complete and return within 10 days of visit.

Time spent preparing for visit: \_\_\_\_\_

Travel time to/from visit: \_\_\_\_\_

Mileage incurred to/from visit: \_\_\_\_\_

Time spent at visit: \_\_\_\_\_

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