

**Ohio Department of Health • Bureau of Child and Family Health Services**

**Child and Adolescent Health**

Complete name, SSN or CFHS client # at each encounter

Name (last, first, middle initial)			
Social Security #	CFHS Client #	Birth date / /	
Date of encounter / /	Site letter	Home visit <input type="checkbox"/> Yes	WIC Participant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred BCMH Participant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred HMG Participant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred
Indicate the client's primary insurance status for this encounter (check one) <input type="checkbox"/> A. Medicaid (HS/HF)-enrolled only <input type="checkbox"/> D. Uninsured/underinsured-Partial Pay <input type="checkbox"/> B. Private insurance <input type="checkbox"/> E. Uninsured/underinsured-No Pay <input type="checkbox"/> C. Uninsured/underinsured-Full Pay <input type="checkbox"/> F. Other (specify optional) _____		If Uninsured/underinsured, indicate status (check one) <input type="checkbox"/> A. CPA completed <input type="checkbox"/> C. Medicaid ineligible <input type="checkbox"/> B. Medicaid eligibility pending <input type="checkbox"/> D. Client refused Medicaid	

**Complete Section 1 at first encounter only**

**1. Mother's Social Security Number**—optional  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Complete Section 2 at every encounter**

**2. Breastfeeding Status** (for clients ages 23 months or younger only)  
 A. Currently breastfed  
 B. Ever breastfed—length of time breastfed \_\_\_\_\_ weeks  
 C. Never breastfed

**3. Type of Encounter** (check one)  
 A. Direct care (Complete 2-11)  
 B. Enabling (Complete 5-12 as applicable)  
 C. Direct care and enabling (Complete 2-12)

**4. Purpose of Direct Care Encounter** (check one)  
 A. Comprehensive health (Complete 5-11)  
 B. Acute care (Complete 5-11 as applicable)  
 C. Follow up (Complete 5-11 as applicable)

**5. Professionals Providing Services** (check all that apply)

<input type="checkbox"/> A. RN	<input type="checkbox"/> G. Licensed Social Worker/Counselor
<input type="checkbox"/> B. LPN	<input type="checkbox"/> H. Licensed/Registered Dietitian
<input type="checkbox"/> C. Nurse Practitioner	<input type="checkbox"/> I. Health Educator
<input type="checkbox"/> D. Nursing/Medical Assistant	<input type="checkbox"/> J. Outreach Worker
<input type="checkbox"/> E. Physician	<input type="checkbox"/> K. Other (specify optional) _____
<input type="checkbox"/> F. Licensed Speech/Language Pathologist	

**6. Height and Weight** (Complete B. if appropriate)  
 A. For all clients, indicate the client's height and weight  
 Ht \_\_\_\_\_ cm or feet/inches    Wt \_\_\_\_\_ grams or pounds/ounces  
 B. For clients ages **23 months and younger**, indicate the client's weight for height:  
 Overweight     Underweight     Normal  
 Not applicable (Enabling, Acute, or Follow up encounter)

**7. Hemoglobin/Hematocrit Values**  
 A. Hgb \_\_\_\_\_ (g/dl)     C. Not tested  
 B. Hct \_\_\_\_\_ (%)     Not applicable (Enabling, Acute, or Follow up encounter)

**For Local Use Only**  
 1. \_\_\_\_\_    2. \_\_\_\_\_

**8. Immunizations Given During Current Encounter**

A. Yes  
 B. No  
 C. Refused  
 Not applicable (Enabling, Acute, or Follow up encounter)

**9. Immunization Status** (at end of current encounter)

A. Complete for age  
 B. In progress  
 C. Incomplete for age  
 D. Unknown

**10. Risk Factors/Risk Behaviors** (check all that apply)

	Self	Home	Other	Referral made
A. Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Emotional/Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Other (specify optional) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Home    Neighborhood    School    Other    Referral made

J. Violence

Not Applicable (Enabling, Acute, or Follow up encounter)

**11. Actions Resulting from Screenings** (check all that apply)

	Assessment	Referral
A. History	<input type="checkbox"/>	<input type="checkbox"/>
B. Physical	<input type="checkbox"/>	<input type="checkbox"/>
C. Lead	<input type="checkbox"/>	<input type="checkbox"/>
D. Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>
E. Hearing	<input type="checkbox"/>	<input type="checkbox"/>
F. Vision	<input type="checkbox"/>	<input type="checkbox"/>
G. Oral health	<input type="checkbox"/>	<input type="checkbox"/>
H. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>
I. Social service	<input type="checkbox"/>	<input type="checkbox"/>
J. Developmental	<input type="checkbox"/>	<input type="checkbox"/>
K. Sexually transmitted infection	<input type="checkbox"/>	<input type="checkbox"/>
L. Other (specify optional) _____	<input type="checkbox"/>	<input type="checkbox"/>

Not applicable (Enabling, Acute, or Follow up encounter)

**12. Type of Enabling Services**—Enter # of minutes spent on each activity

A. Assessment/Counseling _____	E. Transportation assistance _____
B. Education _____	F. Translation service _____
C. Care coordination _____	G. Other (specify mandatory) _____
D. CPA assistance _____	