

**Ohio Department of Health  
Maternal and Child Health Integrated Data System (MCHIDS) – MATCH Encounter Record**

<b>Name</b> (Last, First, Middle Initial)		<b>Birth date</b> (MM/DD/YYYY) / /		<b>Social Security #</b>		
<b>Encounter Date*</b> / /		<b>Facility*</b>		<b>Site Letter</b>	<b>WIC *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred	<b>BCMh *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred
<b>Insurance Status*</b> <input type="checkbox"/> Medicaid (HS/HF) <input type="checkbox"/> Uninsured/Underinsured (Partial Pay) <input type="checkbox"/> Private Insurance		<input type="checkbox"/> Uninsured/Underinsured (No Pay) <input type="checkbox"/> Uninsured/Underinsured (Full Pay) <input type="checkbox"/> Other _____		<b>Uninsured / Underinsured Status*</b>	<input type="checkbox"/> Medicaid Application Assistance	<input type="checkbox"/> Medicaid Eligibility Pending <input type="checkbox"/> Medicaid Ineligible <input type="checkbox"/> Client Refused Medicaid
<b>Household Size*</b>	<b>Household Income*</b> \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 2X Per Month <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Annual			<b>Income Verified*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Source of Referral*</b> <input type="checkbox"/> Advertisement/Self <input type="checkbox"/> Family Planning Clinic <input type="checkbox"/> Private Physician <input type="checkbox"/> Other <input type="checkbox"/> BCMH <input type="checkbox"/> Friend/Family <input type="checkbox"/> Perinatal Clinic <input type="checkbox"/> Current/Former Client <input type="checkbox"/> Help Me Grow Hotline <input type="checkbox"/> School System <input type="checkbox"/> DJFS/Children Services <input type="checkbox"/> Infant/Child Adolescent Clinic <input type="checkbox"/> WIC <input type="checkbox"/> Early Intervention Agency <input type="checkbox"/> Outreach Worker <input type="checkbox"/> Emergency Room Hospital <input type="checkbox"/> Social Security Agency						
<b>Migrant Worker*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Amish*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Mother's Social Security #</b>		<b>Type of Encounter*</b> <input type="checkbox"/> Direct Care <input type="checkbox"/> Enabling <input type="checkbox"/> Direct Care & Enabling <input type="checkbox"/> Home Visit		
<b>Purpose of DC Encounter*</b> <input type="checkbox"/> Comprehensive <input type="checkbox"/> Acute Care <input type="checkbox"/> Follow Up				<b>Breastfeeding Status</b> <input type="checkbox"/> Currently BF <input type="checkbox"/> Ever BF <input type="checkbox"/> Never BF Number of weeks _____		
<b>Professionals Providing Services*</b> <input type="checkbox"/> RN <input type="checkbox"/> Nursing/Medical Assistant <input type="checkbox"/> Licensed Social Worker <input type="checkbox"/> LPN <input type="checkbox"/> Physician <input type="checkbox"/> Licensed/Registered Dietitian <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Licensed Speech/Language Pathologist <input type="checkbox"/> Health Educator <input type="checkbox"/> Outreach Worker <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Other _____						
<b>Height and Weight*</b>		<b>Height</b> English _____ feet _____ inches Metric _____ cm		<b>Weight</b> English _____ lbs _____ oz Metric _____ grams		<b>Hemoglobin / Hematocrit *</b> <input type="checkbox"/> Not Tested <input type="checkbox"/> Not Applicable
<b>Immunizations Given*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> N/A				<b>Immunization Status*</b> <input type="checkbox"/> Complete for age <input type="checkbox"/> Incomplete for age <input type="checkbox"/> In Progress <input type="checkbox"/> Unknown		
<b>Risk Factors / Risk Behaviors*</b> <input type="checkbox"/> None Identified <input type="checkbox"/> Not Applicable						
	Self	Home	Other	Referral Made	School	Neighborhood
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Emotional / Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
E-Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Secondhand Smoke Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Neglect	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>	N/A	N/A
Sexually Active	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>	N/A	N/A
Physical Abuse	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>	N/A	N/A
Sexual Abuse	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>	N/A	N/A
Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Other	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**5A's Intervention\***

**1. Ask**

Smoking Status       Never     Former     Current      Secondhand Smoke : Client  Yes  No    Child/Children  Yes  No

**2. Advise**

Strong Advice to Quit     Benefits of Quitting       Harms of Smoking     Client Refused  
 Difficulty of Quitting     Risks of Secondhand Smoke Exposure

**3. Assess**

Willingness to quit in 30 days     Yes    Set Quit Date\* \_\_\_\_/\_\_\_\_/\_\_\_\_     No    Reason for not Quitting\* \_\_\_\_\_

State of Change:       Pre-contemplation       Preparation       Maintenance  
 Contemplation       Action

**4. Assist**

Follow-up from Last Visit       Review Problem Solving Skills       Provide Self-help Materials  
 Provide Social Support       Identify Local Social Support       Client Refused

**5. Arrange**

Cessation Specialist / Program       Quit Line       Client Refused

Follow-up Appointment \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

**Comments**

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**Actions Resulting from Screening\***

None Indicated  
 Not Applicable

	Assessment	Referral Made
History.....	<input type="checkbox"/>	<input type="checkbox"/>
Physical.....	<input type="checkbox"/>	<input type="checkbox"/>
Lead.....	<input type="checkbox"/>	<input type="checkbox"/>
Speech Language.....	<input type="checkbox"/>	<input type="checkbox"/>
Hearing.....	<input type="checkbox"/>	<input type="checkbox"/>
Vision.....	<input type="checkbox"/>	<input type="checkbox"/>
Oral Health.....	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition.....	<input type="checkbox"/>	<input type="checkbox"/>
Social Service.....	<input type="checkbox"/>	<input type="checkbox"/>
Developmental.....	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infection....	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive Life Plan.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

**Type of Enabling Services\***

Assessment / Counseling \_\_\_\_\_      Transportation Assistance \_\_\_\_\_  
Medicaid Assistance \_\_\_\_\_      Translation Service \_\_\_\_\_  
Education \_\_\_\_\_      Other \_\_\_\_\_  
Care Coordination \_\_\_\_\_

**Notes**

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**Flag for  
Follow-up**