

Postnatal Encounter Visit Form

(Completed one time per month)

__ Birth-12 months __ 13+ months

Home Visitor: _____

Date of Visit: _____

Child's DOB: _____

Child's Age: _____

Parent/Caregiver Name:	Index Child Name:
<u>TOBACCO SURVEY (GUARDIAN TAB)</u>	
1. Are you currently smoking or using tobacco products? <input type="checkbox"/> Smoking Cigarettes; # of cigarettes per day? _____ <input type="checkbox"/> Using Tobacco Products <input type="checkbox"/> E-Cigarettes <input type="checkbox"/> N/A	
2. Are you interested in quitting/reducing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
3. Does anyone else in the home smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is your baby ever around tobacco smoke inside or outside your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Which of the following statements best describes the rules about smoking inside your home now, even if no one who lives in your home is a smoker? <input type="checkbox"/> No one is allowed to smoke anywhere inside my home <input type="checkbox"/> Smoking is allowed in some rooms or at sometimes <input type="checkbox"/> Smoking is permitted anywhere inside my home	
<u>GUARDIAN MEDICAL VISIT (for primary caregivers with a child less than 12 months of age)</u>	
6. Did you attend a postpartum visit after delivery? <input type="checkbox"/> Yes, date of visit: _____ <input type="checkbox"/> No <input type="checkbox"/> N/A	
<u>CHILD MEDICAL VISIT (CHILD TAB)</u>	
7. Well-Child Visit attended this month? <input type="checkbox"/> Yes; date of visit: _____ <input type="checkbox"/> No	
8. Has your child been to the Emergency Department due to an injury since our last visit? <input type="checkbox"/> Yes, # of visits: _____ <input type="checkbox"/> No	
<u>LITERACY ACTIVITIES (CHILD TAB)</u>	
9. How many days during a typical week were you or a family member able to read, tell stories and/or sing songs to/with your child? # of days: _____	
<u>BREASTFEEDING SURVEY (for children less than 12 months of age) (CHILD TAB)</u>	
10. Are you currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, date stopped): _____ <input type="checkbox"/> Never breastfed <input type="checkbox"/> N/A	
11. Do you exclusively breastfeed (breast milk only, including pumped)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
<u>SAFE SLEEP SURVEY (for children less than 12 months of age) (CHILD TAB)</u>	
12. Does your baby have a crib, bassinet, or Pack & Play to sleep in? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Does your baby:	
a. Always sleep alone in a crib, bassinet, or Pack & Play? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Always get placed to sleep on his/her back? <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Always sleep in a crib, bassinet, and/or Pack & Play that is free of soft bedding including heavy or loose blankets, pillows, toys, or other objects? <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Always sleep in a crib, bassinet, or Pack & Play that is free of bumper pads? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Does your baby ever sleep with anyone in an adult bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. If home visitor provided safe sleep education during the home visit, was the caregiver engaged in face-to-face discussion with the home visitor (including Q&A) about the educational materials? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Education was not provided at this visit	
16. If home visitor provided <i>Period of Purple Crying</i> education during the visit, was the caregiver engaged in face-to-face discussion with the home visitor (including Q&A) about the educational materials? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Education was not provided at this visit	