Care Plan (Sample Format)

Psychosocial Assessment			Recipient's Chief Concern						PREGNANCY OUTCOME
	Yes	No		Yes	No		Yes	No	Date
1. Recipient Very Concerned About Pregnancy			7. Conflict/Violence in the Home			13. Child Care Needs			Pregnancy Ended _____
2. Poor Previous Pregnancy Experience			8. Unable to get Prenatal Care			14. Housing Needs			Postpartal/Family Planning Visit _____
3. Poor Support System			9. Family Has Urgent Health Needs			15. Transportation Needs			Postpartal/WIC Certification _____
4. Depression, Other Mental Health Issues			10. Insufficient Funds of Food			16. School Needs			Infant Certified for WIC _____
5. Drugs/Alcohol/Tobacco Usage			11. Difficulty Obtaining Food Stamps			17. Employment Needs			HealthCheck Referral _____
6. Religious/Ethnic/Cultural Factor Affecting Pregnancy			12. Difficulty Enrolling in WIC			18. Child Support Difficulty			Closed for Care Coordination Services _____

Name — Recipient	Medicaid ID Number	Agency Name

Problems / Concerns	Date Detected	Gestational Age	Actions Take	Resolved / Improved?
POSTPARTUM VISITS AND INFANT CARE REFERRAL				

Care Coordinator Checklist (page 1)

Name — Recipient	Medicaid ID Number	Agency Name

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)

DATE:											
Location of contact: Office visit											
Home visit											
Telephone visit											
Gestational age											
Discuss recipient's concerns											
Follow up on previous referrals											
Continue screening for abuse, stress, need for mental health and social services											
HEALTH PROMOTION / EDUCATION											
Continue nutrition counseling, referral											
Risks to avoid: medications, chemicals, etc.											
Monitor smoking, alcohol, drug use											
Managing common discomforts											
Warning signs of pregnancy											
Promote breastfeeding											
Maternal seatbelt use, infant car seat safety											
Preterm labor symptom recognition											
Preparation for labor/birth											
Promote prenatal/parenting class											
Signs of labor – where/when to go											
Signature											

Care Coordinator Checklist (page 2)

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)

DATE:											
TRANSPORTATION ASSISTANCE											
Contacted county transportation											
Contacted HMO transportation											
Other, specify _____											
CHILD CARE ASSISTANCE											
Contacted county child care assistance											
Other, specify _____											
SPECIAL COMMUNICATIONS											
Contacted county child care assistance											
Received information from primary care provider											
Client needed extra appointment reminders and follow up											
Communications with referral providers											
OTHER _____											
Signature											