

Check if prenatal

Nurturing Families Network Intake

Site Submitting Intake to UHA: _____

Re-Entry?

Re-entry Date: / /

A. Participant Information

Date of referral: ___/___/___ Date Referral received by Site: ___/___/___ Referral Source: _____
Town of Residence: _____

Mother's DOB: ___/___/___ Father's DOB: ___/___/___ Infant's DOB: ___/___/___ or EDD ___/___/___

Program offered face to face by: NFN Staff Community agency N/A (not offered) Date offered: ___/___/___

Location program offered at: Hospital Prenatal clinic Other health clinic Community agency
NFN Site Other

Educational presentation completed: Yes No If yes, date ___/___/___

B. REID Screen

Screener's Name: _____ Date of screen: ___/___/___ NFN Screening Site: _____

- ___ 1. Mother is single, separated, or divorced
- ___ 2. Partner unemployed.
- ___ 3. Inadequate income or no info on income
Type _____
- ___ 4. Unstable housing
- ___ 5. No phone
- ___ 6. Education under 12 years (specify _____)
- ___ 7. Inadequate emergency contacts
- ___ 8. History of substance abuse: Type _____
- ___ 9. Late (after 12 weeks), none, or poor Prenatal Care
- ___ 10. History of abortions
- ___ 11. History of psychiatric care
- ___ 12. Abortion unsuccessfully sought or attempted
- ___ 13. Adoption sought or attempted
- ___ 14. Marital or family problems
- ___ 15. History of, or current depression
- ___ 16. Mother is age 18 or younger
- ___ 17. Mother has a cognitive deficit

***FOR THE SCREEN TO BE POSITIVE, 3 items must be true or 8 items must be unknown or items 8, 11, 14, or 15 are present with one other item**

C. Positive Screen (To be completed by Nurturing Connections/NFN Screener)

If screen positive, was family offered home visiting? Yes No

If yes, did family initially accept home visiting? Yes No

****This box completed by FAS****

If yes, was Kempe completed? Yes No
Date KEMPE completed: ___/___/___
Reason KEMPE not completed: _____

Was the first home visit completed?
Yes No

If yes, Date of visit: ___/___/___
If no, reason 1st visit not completed: _____

Family ID # _____

Home Visitor: _____

Is family acute? Yes No

If yes, circle reason

Domestic Violence Substance Abuse
Mental Health

If no, circle reason 1) HV full 2) Language barrier 3) out of catchment area 4) no face to face contact 5) DCF involved 6) other

Family offered Nurturing Connections?

Yes No

Family Accepted Nurturing Connections?

Yes No

If yes, Family ID # _____

Other services offered: _____

If no, circle reason

- 1) no time for HV
- 2) family has enough support
- 3) household member or partner does not approve
- 4) other _____
- 5) Family said maybe/not sure

Family offered Nurturing Connections? Yes No

Family accepted NC? Yes No

If yes, Family ID # _____

Other services offered? Yes No

D. Negative Screen (To be completed by Nurturing Connections/NFN Screener)

If screen negative, was family offered Nurturing Connections? Yes No

If YES, Family Accepted Nurturing Connections: Yes No

If yes, Family ID # _____

If NO, circle reason:

- 1) NC program full
- 2) language barrier
- 3) out of catchment area
- 4) no face to face contact
- 5) DCF Involved
- 6) family has no phone
- 7) Other _____

Other services offered:

Yes No

Nurturing Families Network Intake- Site Information

E. Family Information

Mother

Name: _____ Phone # _____ Cell#: _____

Address: _____

Primary Language: _____ Preferred Language: _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partner/Sig. Other ___

Ethnicity: Hispanic ___ African American ___ Caucasian ___ Other ___ (specify _____)

Education: Grade 1-8 ___ 9-12 ___ HS grad or GED ___ Voc. Training: ___ Some college ___ Assoc degree ___
Bachelor's degree ___ Post Grad ___ Other ___ Unknown ___

Currently in school? Yes No If yes, what grade: _____

Employed? Yes No If yes, Full-time ___ Part-time ___ Active military ___ Not employed ___ Unknown ___

Source of income: FOB ___ Self ___ Parent(s) ___ TANF ___ SSI ___ Food Stamps ___ WIC ___ Other ___

Emergency Contact: _____ Relationship to mother: _____

People in Household: _____

Mother's OB/GYN: _____

Mother has insurance? Yes No

If yes, type: ___ Medicaid/Title 19 ___ HUSKY ___ Private ___ Other

Infant

Name: _____ Sex: M ___ F ___ Gestational age: _____ weeks

Birth Weight: ___ lbs. ___ oz. Type of birth: Vaginal ___ Cesarean ___ Unknown ___

Feeding: Breast ___ Bottle ___ Both ___ Undecided ___ Unknown ___

Pediatrician: Yes ___ No ___ If yes, name of pediatrician _____

Father

Name: _____ Phone # _____

Address: _____

Primary Language: _____ Preferred Language: _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partner/Sig. Other ___

Ethnicity: Hispanic ___ African American ___ Caucasian ___ Other ___ (specify _____)

Education: Grade 1-8 ___ 9-12 ___ HS grad or GED ___ Voc. Training: ___ Some college ___ Assoc degree ___
Bachelor's degree ___ Post Grad ___ Other ___ Unknown ___

Currently in school? Yes No If yes, what grade: _____

Employed? Yes No If yes, Full-time ___ Part-time ___ Active military ___ Not employed ___ Unknown ___