Northwestern Ohio Community Action Commission
Early Head Start Two Week Home Visit

Child' Name_____ M___ F___ Due Date_____ Date of Birth_____

Location of Birth_____ Premature N___ Y____ How many weeks_____ Jaundiced N____ Y____ Follow Up_____

Concerns: Type Of Birth/During/After The Birth_____

Concerns: Child Development/Disabilities _____

Umbilical Cord Concerns N____ Y____ What_____ (M) Circumcised N____ Y____ Concerns_____

Well Baby Exam (Review Of Comprehensive Physical Section) - Concerns/Follow Up (FU) For Any Abnormal Findings (A)

A_____ FU_____ A_____ FU_____ A_____ FU_____

Other (Allergies, Medication, etc.)_____

List All Doctor(s) Name And Why_____

Medical Provider_____ _____

Name Address/Suite City State Zip Phone

Medical Insurance:_____ Plan/#_____ WIC N____ Y____

Well Baby Exam

Review Of Development/Behavioral)
List Screenings(S) Not Completed
Follow Up (FU) Needed

;_____FU_____

;_____ FU_____

;_____ FU_____

Referrals

Immunizations

Hep B N____ Y____ FU_____

Breast Feeding

Breast Feed N_____Y_____ Breast Every_____ Hrs Concerns_____

Formula Brand_____ Oz_____ Every _____Hrs.

Concerns_____

Baby have at least 4 wet diapers in a 24 hr period N____ Y____ Concern_____

Sleep 2-4 hours N____ Y____ Concern_____

Applied For:

Birth Certificate N _____ Y_____ Social Security # N _____ Y_____ FU_____

Family Members Present
Circle all that apply

Mother Father Aunt
Grandmother Grandfather
Partner Other_____

Next Well Exam 2 month

Date_____

Educational Materials Reviewed/Given/Requested

Safety: __ Never Shake Baby __ Car Seat __Home/Car Smoke Free __Don't Leave Baby Tub

Nutrition: __Hold Baby Feeding __Breast/Bottle Feed Demand __Iron-fortified Formula

Infant Care: __Thermometer Use __Wash Hands __Diaper Changes __Emergency Procedures
__Sleep/Feed Routines __Safe Sleep Back/Own Crib __ Console, Play, Cuddle, Hold

Family: __Postpartum Check up/Depression __Family Planning __Family Support(who)

Additional Requested Resources:

Referrals requested (Circle): OB/GYN Pediatrician Lactation Consultant Childcare WIC
Help me grow Medicaid Substance Use Tobacco Cessation
Other:

Parent/Guardian Sign_____ Date:_____

Staff Sign_____ Date:_____

HB Manager Initials