|  |
| --- |
| **1 unit/encounter** |

**Babies First/CaCoon Targeted Case Management (TCM) Visit Form**

Use with TCM Assessment and Plan

|  |
| --- |
|  |

**TCM CARE PLAN REVIEW:**

|  |  |  |  |
| --- | --- | --- | --- |
| Client and RN identified needs/priorities reviewed | [ ]  Initial visit – see plan | [ ]  Change | [ ]  No Change |
| Client TCM plan reviewed | [ ]  Initial visit – see plan | [ ]  Change | [ ]  No Change |
| *(Identified changes to be documented on client TCM service plan and TCM Assessment Form)* |
|  |

**ACTIVITIES:**

|  |  |  |
| --- | --- | --- |
| **[ ]**  | Client identified barriers this date of service: |  |
| **[ ]**  | Identified strengths this date of service: |  |
| **[ ]**  | Shared info about community resources: |  |
| **[ ]**  | Assisted family to work with agencies: (list agency) |  |
| **[ ]**  | Assisted family to complete paperwork for: |  |
| **[ ]**  | Supported and advocated for needed services: |  |
| **[ ]**  | Problem solved with family to expand support system: |  |
| **[ ]**  | Problem solved with family to obtain transportation to services: |  |
| **[ ]**  | Used motivational interviewing techniques to motivate client to adhere to plan: |  |
| **[ ]**  | Other: |  |
|  |

**REFERRALS:**

Made referrals: (record referrals on ORCHIDS data form)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Dental |  [ ] Child Care  |  [ ]  Early Intervention/ESCE | [ ]  Special Education |  [ ]  OHP/Health Insurance  |
| [ ]  Specialty Health Care Provider |   [ ]  Transportation |   [ ]  WIC  |   [ ]  Immunizations |
| [ ]  Basic Needs: foodclothin, g, shelter (specify) |       |
|  |  |
| [ ] Primary Health Care Provider      |  | [ ] Other (specify)      |  | [ ] Other (specify)      |  | [ ] Other (specify)      |
|   Assisted Client with Appointment Scheduling:      |
| Appointment: |       | Date: |       |
|  |

**MONITOR:**

|  |  |
| --- | --- |
| [ ]  Referral outcomes from previous visit: |       |
|  [ ]  UTD on well child care | Next WCC due: |       |
|  [ ]  UTD Immunizations | Next Immunizations due: |       |
| [ ]  UTD on specialty care | [ ]  Access to quality child care | [ ]  Early education services |
| [ ]  Access to basic needs/supplies |  [ ]  SSI | [ ]  Transportation | [ ]  Health insurance/OHP status |
| [ ]  Continuing to access previous referral connections as recommended |  |
| [ ]  Parent/Caregiver commitment to service plan continues |  |
| [ ]  Other: |       |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **TCM RN Case Manager Signature:** |  | **Date:** |  |
| **Home Visitor Signature:** |  | **Date:** |  |
| **Client Name:** |  | **DOB:** |  |

Rev/11.2011