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

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

Use with TCM Assessment and Plan

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|  |

**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: |  | | | | | | | | | | |
|  | | | | | | | | | | | |

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

Rev/11.2011