



Oregon MothersCare Client Tracking Form

Record ID: _____

OMC Site Code/Name:		Date of Initial Contact:	Date of Birth:	Referred by*:
First Name:		Preferred name*:	Phone Number (1 st)*: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> message	
Last Name:			Phone Number (2 nd)*: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> message	
Street Address*:		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown		
Mailing Address*:		Language: <input type="checkbox"/> Cantonese <input type="checkbox"/> English <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:		
City:	Zip:	Race (check all that apply): <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown <input type="checkbox"/> Other		
Email Address*:				

Client Screening

LMP Date:	EDD Date*:	"High Risk" pregnancy: <input type="checkbox"/>	
Current WIC Client: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Scheduled	Gravida: _____	Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Number: _____	Para: _____	Alcohol User: <input type="checkbox"/> Yes <input type="checkbox"/> No	Breastfeeding Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Income: _____	Abortion: _____	Drug User: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Living Child: _____	Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Client's Current Maternity Insurance – (select one)
 CAWEM CAWEX OHP Private Insurance Other County's CCO Other State's Medicaid FFM Other None

Services Delivered by OMC Site (check appropriate boxes)	Application Information
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Date of Services:	Appt. Time*:	App. Submitted Date:	Reapply Date (same pregnancy)
<input type="checkbox"/> Pregnancy Testing		Insurance applying through: <input type="radio"/> OHP Paper <input type="radio"/> ONE system <input type="radio"/> Online PDF <input type="radio"/> Healthcare.gov <input type="radio"/> Other Community Partner <input type="radio"/> Other <input type="radio"/> Declined	
<input type="checkbox"/> OHP Application Assistance			
<input type="checkbox"/> Referral to OHP Community Partner		Approval: <input type="checkbox"/> OHP Approved <input type="checkbox"/> CAWEX Approved <input type="checkbox"/> QHP Approved	
<input type="checkbox"/> Prenatal Care Provider Selected			
<input type="checkbox"/> PNC Appt. Scheduled/or Confirmed by OMC Site			
<input type="checkbox"/> Initial Prenatal Needs Assessment			
<input type="checkbox"/> WIC Screening / Referral			
<input type="checkbox"/> MCM / Home Visiting Referral			
<input type="checkbox"/> Other Community Referrals			
<input type="checkbox"/> Attendance at 1st Prenatal Visit <u>before</u> OMC Conf.			
<input type="checkbox"/> Dental Referral/Education <input type="checkbox"/> Completed Dental Referral			
<input type="checkbox"/> Smoking Cessation Education and Referral			

Prenatal Care Information

Has client started PNC prior to OMC? <input type="radio"/> Yes** (**indicate date below) <input type="radio"/> No	
Name of Prenatal Care Provider or Clinic:*	
Date 1st PNC <u>before</u> OMC: **(If answered Yes above)	Date PNC <u>after</u> OMC contact:
If no date above, select reason below:	
<input type="checkbox"/> Declined	<input type="checkbox"/> TAB (Abortion)
<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> SAB (Miscarriage)
<input type="checkbox"/> Option Undecided	<input type="checkbox"/> Transferred Care
<input type="checkbox"/> Will Make Own Appts	<input type="checkbox"/> Gave Birth
<input type="checkbox"/> Pending OHP Approval	<input type="checkbox"/> Pending Clinic Response

Notes*: _____

Form Complete?
Yes <input type="checkbox"/> No <input type="checkbox"/>

* Indicates fields not tracked by OMC state office and are for your office use only.