**MR #: _____**

## INFANT SUPPORT SERVICE CONTINUING PATIENT CARE FORM

| | |
|---|---|
| Infant Last Name First<br><br>MOTHER NAME: | Agency Name and Address **Crystal Home Healthcare MIHP**<br>15819 Schoolcraft Road Detroit, MI 48227<br>Phone: (313) 493-4900 Fax: (313) 493-4904 |
| Address For Care<br><br>City State Zip | Referral By:<br><br>Referral Date: Reported By:<br><br>Agency 1st Visit Date: Reported By: |
| Patient Address if not the same as above | Medicaid: _____ ❍**Pending**<br><br>HMO/Other: _____<br><br>Mom Medicaid:_____Mom DOB_____ |
| Home #: Cell #:<br><br>Responsible relative or friend:<br><br>Relationship Phone | Pediatrician/Clinic Phone# _____<br><br>Fax# _____<br>Address _____ |
| Complete Birth Date Sex : ❍Male ❍Female<br><br>Birth Weight_____<br><br>_____/_____/_____ Length _____ | Hospital Born At _____ City_____ |

### Plan of Care

Assess and Evaluate

☐Growth and Development ☐Neurological Status ☐Hydration/Nutrition

Assess/Evaluate Functioning

☐Bonding ☐Growth and Development Stimulation
☐ Safety ☐Comfort Measures/Cry Response

Knowledge Deficit/Health Promotion

☐S&S Illness in Infant ☐Alternate Care Giver ☐Umbilical Cord/Circ Care
☐Infant Care Bathing & Dressing ☐Medical Appointments ☐Infant Feeding/Formula Prep
☐Immunizations ☐Infant Activity/Rest Cycle

HISTORY (Risk Criteria)

☐Abuse of alcohol or drugs, especially use of cocaine
☐Mother under the age of 18 **and** has no family support
☐Family history of child abuse/neglect
☐Failure to thrive
☐Low birth weight (less that 2500 grams) 5lbs, 5oz.
☐Mother was cognitive, emotional or mental impairment (low functioning mother)
☐Homeless or dangerous living/home situation
☐Any other condition that may place the infant at risk of death, significant impairment, or illness

**Client Needs:**

☐ WIC
☐ Breastfeeding
☐ Parenting Classes
☐ Housing
☐ Food
☐ Transportation
☐ Pediatrician Ref
☐ Baby Items

************This form can be faxed back to 313.493.4904************

| CRYSTAL HOME HEALTHCARE FIELD STAFF USE ONLY | | | | |
|---|---|---|---|---|
| TIME & DATE OF VISIT ATTEMPTS | Attempt 1 Time_____am pm<br>Date _____/_____/_____<br>❍Drive By ❍Call ❍Letter | Attempt 2 Time_____am pm<br>Date _____/_____/_____<br>❍Drive By ❍Call ❍Letter | Attempt 3 Time_____am pm<br>Date _____/_____/_____<br>❍Drive By ❍Call ❍Letter | RETURNED TO OFFICE DATE |
| PLAN OF CARE VISITS | SW Anticipated Visits | RN Anticipated Visits | RD Anticipated Visits | Case Mgr Initials |