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ICPSR 34312

Maternal Lifestyle Study in Four Sites in the United States, 1993-2011

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Questionnaires for Phase II: M12
Mother/Caregiver Report Data, Agency Report

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Center Number	Screening Number	Visit Month	Report Number	Birth Number
		1 4 8 10 12 16 24 30 36		

AGENCY REPORT

Instructions to the Agency: Please refer to your records for our client identified in Part I below and follow instructions found on top of page 2.

Instructions to the Case Manager/Social Worker Requesting Information:

1. Assign a sequential Report Number at top of page. Start with 1 and if more than one report is required for this client at this visit, then continue numbering sequentially.
2. Complete identifying information in Part I and form completion box at bottom of page.
3. Complete all shaded areas in Part II for the Agency.
4. For Part II, Question 2, choose only one service unless integrated or in-patient services were provided by the Agency. If integrated or inpatient services, choose all that apply.

PART I. CLIENT IDENTIFYING INFORMATION (Completed by the Case Manager/Social Worker requesting information)

REDISCLOSURE PROHIBITED

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations (42 CFR Part 2) and prohibits you from making further disclosure of it without specific consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

A. Client Information

1. Client's Name: _____
   First Last
2. Date of Birth: __ __ / __ __ / __ __
   Month Day Year
3. Social Security Number: __ __ __ – __ __ – __ __ __ __
4. Therapist Name: _____
5. Agency Name: _____
6. Agency Address: _____

_____

Form completed by: FORMIN (First Last)

Date form sent: FORMDT (Month Day Year)

THE EFFECTS OF MATERNAL LIFESTYLES ON INFANT OUTCOMES

Center Number | Screening Number | Visit Month (1 4 8 10 12 18 24 30 36) | Report Number | Birth Number

Instructions to the Agency:

1. Please review the services marked in 2 below and check your records to confirm that your agency provided these service(s) to our client.
2. A seperate Agency Report is completed for each service unless services are inpatient or integrated (e.g., services to the child or caretaker provided together within the same session with the same therapist/staff member).
3. For each marked service, record "yes" if it was provided by your agency, otherwise record "no".
4. If your agency provided a service listed in 2 which was not marked or indicated on a separate Agency Report form, note information on this service under Additional Comments below.
5. Complete Part II only for the selected service(s) marked as provided by your agency and confirmed in 2 below.
6. If none of the indicated service(s) were provided by your agency, record "no" in 2, complete 6 and 7, and return the form.

PART II. REPORT ON SERVICE RECEIVED (Completed by the Agency providing services)

B. Report on Services Received

1. Period of time covered by this report from

a. Date of last report (or date of birth) ARLSTDT (Month Day Year) to b. Date of current report ARCURDT (Month Day Year)

2. Kind and Type of Services

Child Services	Client Reported Received	Confirmed by Agency Yes	Confirmed by Agency No
a. Physical Therapy (Bf)	ARBFSRV	ARBFCON	
b. Occupational Therapy (Bg)	ARBGSRV	ARBGCON	
c. Early Intervention (Bh)	ARBHSRV	ARBHCON	
Adult Services			
d. Parent Training (Ch)	ARCHSRV	ARCHCON	
e. Adult Education/Job Training (C	ARCKSRV	ARCKCON	
f. Counseling (Dc)	ARDCSRV	ARDCCON	
g. Mental health - Inpatient (Dd)	ARDDSRV	ARDDCON	
h. Mental health - Outpatient (De)	ARDESRV	ARDECON	
i. Alcohol/drug treat. - Inpatient (I	ARDGSRV	ARDGCON	
j. Alcohol/drug treat. - Outpatient	ARDHSRV	ARDHCON	

3. Are services ended? YES NO ARENDSV

If yes, complete a and b.

a. Date of Termination/Discharge ARENDDT (Month Day Year)

b. Did the client complete the Service/Treatment Plan? YES NO ARENDCO

THE EFFECTS OF MATERNAL LIFESTYLES ON INFANT OUTCOMES

Center Number | Screening Number | Visit Month (1 4 8 10 12 18 24 30 36) | Report Number | Birth Number

4. Was this an inpatient service? YES NO — ARINPSV

If no, complete a and b.

a. Number of kept visits for the time period covered by this report [See Question 1] — ARINPNO

b. Percentage of appointments kept — 0-20% 21-40% 41-60% 61-80% 81-100% — ARINPER

5. Rate the Client's progress — Poor Fair Good Excellent — ARPROGR

6. Date report completed — ARRPTDT (Month Day Year)

7. Report completed by: _____
Name of therapist or staff member

Additional Comments:

_____

_____

_____

_____

_____

_____

To be completed by Maternal Lifestyles study personnel:

8. Was this report completed by the agency? No Yes-Phone Yes-Mail Yes-Other — ARAGECO

a. If yes, date received: — ARAGEDT (Month Day Year)