FAMILY DEVELOPMENT

Activity Services Form

Date: *	_____/_____/_____ Month Day Year
Type:	○ For one person ○ For the entire Family ○ N/A
Family Person:	_____ _____ _____ First name M.I. Last name
Service Type: *	○ Brokering ○ Direct service ○ Follow-up with family ○ Follow-up with Provider ○ Letter ○ Other ○ Referral (To Outside of HS) ○ (Referral Within HS) ○ Supportive discussion
Contact Type:	○ Dental visit ○ Home visit ○ Immunization ○ Office group session ○ Office Visit ○ Other contact ○ Other location ○ Other location group session ○ Outreach/Recruitment ○ Telephone
General Service:	○ (Adult) Family Service/legal ○ (Child) Family Services ○ Adult education ○ Basic Life Skills ○ Child care ○ Child Health & Development ○ Clothing ** ○ Communication/Literacy skills ○ Community involvement ○ Early intervention skills ○ Employment ○ Family health ○ Family relationships ○ Housing/Utilities ○ Income ○ Income support ○ Mental health ○ Nutrition ○ Other ○ Parent involvement in Head Start ○ Parenting ○ Reproductive health ○ Social support ○ Substance use ○ Transitions ○ Transportation
Detail Service:	○ Contraceptive supplies ○ Family planning counseling ○ Instruction/support for breast-feeding ○ Other ○ Postnatal care visit ○ Pregnancy test ○ Prenatal care visit
Has received or is receiving treatment:	○ Anemia ○ Asthma ○ Child abuse ○ Dental preventive care (fluoride, cleaning, etc.) ○ Dental screening as part of Well-baby exams ○ Dental treatment ○ Diabetes ○ Diptheria-Tentanus-Pertussis ○ Disability: Autism ○ Disability: Emotion/Behavior disorder ○ Disability: Health impairment ○ Disability: Hearing impairment including deafness ○ Disability: Learning disability ○ Disability: Mental retardation ○ Disability: Multiple disabilities ○ Disability: Non-Categorical/Development delay ○ Disability: Orthopedic impairment ○ Disability: Speech or Language impairments ○ Disability: Traumatic Brain injury ○ Disability: Visual impairment including Blindness ○ Haemophilus Influenza Type B ○ Hearing difficulties ○ High lead levels ○ Hypertension (High Blood Pressure) ○ Hypotension (Low Blood Pressure) ○ Low Birth Weight ○ Measles, Mumps, Rubella ○ Mental Health ○ Nutritional problems ○ Ova & Parasites ○ Overweight ○ Poliomyelitis ○ Seizure ○ Sickle cell ○ Tuberculosis ○ Underweight ○ Vision problems
Days: _____	Hours: _____ Minutes: _____ Cost: _____
Service Method:	○ Family diary ○ Family interview ○ HS provided service ○ Record review ○ Service provider interview ○ Staff member observation ○ Other
Result:	○ Referral ○ Scheduled appt. NOT kept ○ Scheduled Home Visit NOT kept ○ Service completed ○ Service declined ○ Unscheduled Home Visit completed ○ Unscheduled Home Visit declined
Location:	○ Employment Home ○ Hosp/Clinic/Med Office ○ Other ○ School — If other, specify:_____
Comments: (Please use back of form for additional comments)	

***** Required Fields ****** PIR Items