CMBHS
Clinical Management for Behavioral Health Services

Life Event Note

Client Name: _____ Date of Birth: _____

Client Number: _____ Gender: _____

Local Case Number: _____ Organization: _____

Note Detail

Life Event Note Type	Case Management - Delivery
Performed By	
Contact Type	
Service Location	
Service Location Other	
Service Date	(mm/dd/yyyy)

Postpartum Information

From assessment to delivery, was client abstinent from alcohol, tobacco and other substances?	○ Yes ○ No ○ Unknown
Did the client receive pre-natal care?	○ Yes ○ No ○ Unknown
Was the client a Mommies participant?	○ Yes ○ No ○ Unknown
How many live births occurred during this delivery?	

Child Information

No	Child's Name	Gestational age at delivery (in weeks)	Client's child born at full term? **Yes / No / Unknown**	Client's child born at healthy birth weight? **Yes / No / Unknown**	Does the child have a Medicaid ID? **Yes / No**	Child's Medicaid ID
1						
2						
3						
4						
5						
6						
7						
8						
9						

Comments	