



Memorandum

#12-085

TO: WIC Regional Directors
WIC Local Agency Directors

FROM: Linda Brumble, Unit Manager
Nutrition Education/Clinic Services Unit
Nutrition Services Section

DATE: August 24, 2012

SUBJECT: Revised VENA Family Documentation Tool Form

This memo is to inform you that the VENA Family Documentation tool has been revised and was sent to the warehouse earlier than expected. Please deplete your stock of the current form by October 1st and begin using the revised form on that date. If your agency still has old forms on October 1st, please recycle them. Please note the following:

- The required information remains the same.
- Several of the boxes have been repositioned and a couple of box titles were modified.
- The “Interim visit” box has been added to improve the participant’s continuity of care. This space was added to provide a place to document any services the participant received between certification visits. The information allows the CA/WCS to know what services, changes, etc. have taken place between certifications. This information will allow staff to better serve the participants.
- Updated instructions are attached and should replace the instructions that are found in the *Clinic Assessment Manual* under the “Instructions: Completing Forms” tab.
- Monitoring of the revised form will begin on April 1, 2013.

If you have any questions or require additional information, please contact Frances Diep, Nutrition Education Consultant, Nutrition Education/Clinic Services Unit, at (512) 341-4584 or frances.diep@dshs.state.tx.us, Erin Thornberry, Nutrition Education Consultant, Nutrition Education/Clinic Service Unit, at (512) 341-4580 or erin.thornberry@dshs.state.tx.us, or Anita Ramos, Training Specialist, Nutrition Education/Clinic Services Unit, at (512)341-4581 or Anita.Ramos@dshs.state.tx.us.

Instructions for Completing the VENA Family Documentation Tool

Staff shall complete the VENA Family Documentation Tool at each certification. Staff members may use this tool at other counseling sessions (high risk counseling, formula issues, etc.) to enhance communication among staff and provide continuity of care for clients.

- One documentation tool shall be completed per family per certification
- Documentation shall be concise, providing a snapshot of the session
- Documentation is required in all fields. If a field is not applicable, the counselor shall document this (e.g. “client is not ready to set a goal”, “none”, etc.). Interim Visit shall only be completed as needed.

Explanation of Fields

Parent/Guardian: Document the first and last name of the parent/guardian

Parent/Guardian’s DOB: Document the date of birth (DOB) of the parent/guardian

Date: Document the date of the counseling session

Staff Name/Initials: Counselor shall document his/her name or initials

Progress of Goal Set at Previous Visit: Counselor shall follow-up with the parent/guardian about their previous family goal and document the status, if applicable. If the session does not allow for follow up due to other more meaningful discussion, counselor may document “follow-up not applicable” or “other topics discussed”. Field may be left blank for initial visit.

Staff’s Primary Concern: Counselor shall document the counselor’s primary concern (regarding ABCDEF: anthropometrics, biochemical, clinical, dietary, environmental, and family information).

Parent/Guardian’s Primary Concern/Interest: Counselor shall document the parent/guardian’s primary concern or interest.

Topics Discussed: Counselor shall briefly document the topics discussed. Documentation shall reflect that the parent/guardian’s primary concern was addressed.

S.M.A.R.T. Goal (Specific, Measurable, Attainable, Realistic, Timely): Counselor shall document the parent/guardian’s family goal, if applicable. The counselor may assist the parent/guardian in setting a goal, but the counselor shall not set the goal for the client.

Referrals Discussed: Counselor shall identify the referral(s) discussed during the session, if applicable. Staff may document additional information about MD referral in space provided.

Interim Visit: Any interim visit that is not documented on the VENA Family Documentation Tool shall be identified in this section with the date. Staff should identify the visit and use the comment section for any clarification. The purpose of this section is to enhance continuity of care.