

# MATERNAL INFANT HEALTH PROGRAM RISK SCREENING TOOL

**Beneficiary Referred For MIHP**

Yes       No

**Beneficiary Name:** \_\_\_\_\_  
Last                      First                      Middle

**D.O.B.:** \_\_\_\_\_

**Medicaid ID #:** \_\_\_\_\_

**E.D.C.:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Beneficiary's Parent/  
Guardian/Spouse:** \_\_\_\_\_

**Alternate Telephone:** \_\_\_\_\_

**Additional Contact  
Person:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Health Care (Obstetrical) Provider**

**Name:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Medicaid Health Plan**

**Name:** \_\_\_\_\_

**1. Need for childbirth education**

Do you know what to expect at different stages of your pregnancy?  
 Yes       No  
 Would you like to learn more about delivery?  
 Yes       No  
 Do you have experience in caring for a baby?  
 Yes       No  
 Would you like to learn more about how to take care of your baby?  
 Yes       No

Who can you count on for support from?  
 The baby's father?       Yes       No\*  
 A parent?       Yes       No\*  
 A friend?       Yes       No\*  
 Anyone else? \_\_\_\_\_

**2. Need for transportation to keep medical appointments**

How do you get around?       By car       Public transport  
 How do you plan to get to medical appointments?  
 \_\_\_\_\_

**6. Feelings about current pregnancy**

Have you been pregnant before? \_\_\_\_\_  
 What are your feelings about this pregnancy?  
 Happy       Unhappy\*       Don't Know  
 Did your last pregnancy result in fetal (womb) or neonatal  
 (within 30 days of birth) death?  
 N/A       Yes\*       No  
 Have you experienced death of a prior child before age one?  
 N/A       Yes\*       No

**3. Need for assistance to care for your infant**

Are you good at following directions/instructions?       Yes       No  
 Barriers:       language       literacy\*      Education level \_\_\_\_\_  
 Physical limitations \_\_\_\_\_

**7. Mother with cognitive, emotional or mental needs**

How are you coping with taking care of your baby?  
 Good       Bad\*       O.K.  
 Do you feel stressed?       Yes\*       No  
 Do you have a history of postpartum depression?  
 Yes\*       No  
 Do you have any concerns about your mental or emotional  
 health?       Yes\*       No

**4. Nutrition/Health problems**

Describe your eating habits  
 No. of meals eaten per day \_\_\_\_\_       Skip meals\*  
 Cook at home       Fast food  
 Which beverages do you drink often?  
 Pop       Juice       Water       Milk  
 Do you have any food cravings, e.g. PICA?       Yes\*       No  
 Is your blood low in iron (anemia)?       Yes\*       No  
 Do you have high blood pressure?       Yes\*       No  
 Do you have diabetes now or during other pregnancies?  
 Yes\*       No  
 Have you had problems with weight gain/loss during  
 your pregnancy?       Yes\*       No  
 Do you have any other health problems that concern you?  
 Explain \_\_\_\_\_

**8. Social situation**

Do you worry about somebody mistreating you?  
 Yes\*       No  
 Do you worry about anyone mistreating your child/children?  
 Yes\*       No  
 Are you planning on moving during your pregnancy?  
 Yes       No       Don't Know

**5. Family support**

Are you under 18 years old?       Yes\*       No  
 Who do you currently live with? \_\_\_\_\_  
 Who supported you during pregnancy? \_\_\_\_\_

**9. Use of alcohol, drugs or tobacco products**

Do you smoke?       Yes\*       No  
 Do you drink alcohol (beer, wine, liquor) now that you are  
 pregnant?       Yes\*       No  
 Do you use street drugs?       Yes\*       No  
 Does someone in your household use street drugs?  
 Yes\*       No

A Check/Yes response to any asterisk ( \* ) question indicates automatic referral for MIHP.

Beneficiary's Name: \_\_\_\_\_

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10. Other (explain): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS:**

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Childbirth Education. Enrollment in MIHP is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (\*) question indicates an automatic referral for MSS. Non-asterisk items should be referred based on provider judgment.

**BENEFICIARY:**

I understand I may qualify to receive MIHP, but I do not want these services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL or MIHP CARE PROVIDER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

A Check/Yes response to any asterisk ( \* ) question indicates automatic referral for MIHP.