

**MATERNAL INFANT HEALTH PROGRAM
INFANT RISK SCREENING TOOL**

Infant Referred For MIHP

Yes No

Infant Name: _____
Last First Middle

D.O.B.: _____

Medicaid ID #: _____

County: _____

Address: _____

Telephone: _____

Mother/Caregiver: _____

Alternate Telephone: _____

Additional Contact Person: _____

Telephone Number: _____

Medical Care Provider

Name: _____

Telephone Number: _____

Address: _____

Medicaid Health Plan

Name: _____

1. Need for assistance to care for your infant

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

Describe where you live:

Rent Own your home With relatives
 Shelter* Motel* Car*

2. Failure to thrive

How often do you feed your baby in a day? _____
Do you: Breast feed Bottle feed
Supplement with _____
Is your baby losing weight? Yes* No
Does your baby have any other health problems that concern you?
Explain: _____

3. 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. Low Birth Weight

What was the birth weight of your baby? _____
 >2500 grams or <2500 grams
What week of the pregnancy was your baby born? _____

5. Family support

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

Who can you count on for support from?

the baby's father? Yes No*
a parent? Yes No*
a friend? Yes No*

Anyone else? _____

6. Homeless/dangerous living situation

Do you worry about anyone mistreating your child/children?
 Yes* No
Do you/baby feel safe in your home? Yes No*
Are you planning on moving from current location?
 Yes No Don't Know

7. Family history of mother's abuse/neglect

Have you ever been abused? Yes* No
Have you ever been neglected? Yes* No

8. Abuse of alcohol, street drugs or tobacco products

Do you smoke? Yes* No
Do you drink alcohol (beer, wine, liquor) when you are pregnant?
 Yes* No
Do you use drugs not prescribed by your doctor?
 Yes* No
Does someone in your household use drugs?
 Yes* No

9. Any other condition that may place the infant at risk for death, illness, or significant impairment?

Explain

Completed by: _____ Date: _____

Note: A yes or check to an asterisk (*) question indicates a referral of MIHP. Provider judgment must be used in making appropriate referrals.

Infant's Name: _____

**MATERNAL INFANT HEALTH PROGRAM
INFANT RISK SCREENING TOOL**

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 Parenting 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 MIHP. Non-asterisk items should be referred based on provider judgment.

CAREGIVER:

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: _____

Note: A yes or check to an asterisk (*) question indicates a referral of MIHP. Provider judgment must be used in making appropriate referrals.