Healthy Families
Northern Michigan
Screen Form

INFORMATION

<table>
<thead>
<tr>
<th>Date of screening</th>
<th>Parent name</th>
<th>Parent date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
</tr>
</tbody>
</table>

Race/ethnicity (Check only one)
- [ ] 1 White, non-Hispanic
- [ ] 2 Black, non-Hispanic
- [ ] 3 Hispanic/Latina/Latino
- [ ] 4 Asian
- [ ] 5 Native American
- [ ] 6 Multiracial
- [ ] 7 Other

(Specify _________)

Gender
- [ ] 1 Female
- [ ] 2 Male
- [ ] 3 Other (Specify _________)

Is parent: (check only one)
- [ ] 1 Mother
- [ ] 2 Father
- [ ] 3 Other

Parent’s address

Street______________________________________________________________

Apt  

City/Town_________________________________________________________

ZipCounty________________________________________________________

Parent phone (no phone □)

Home phone- - -

Cell or work phone - - -

Due date/child’s DOB

Month | Day | Year

Parent phone (no phone □)

Home phone- - -

Cell or work phone - - -

Prenatal care: received/receiving?

[ ] Yes  [ ] No  [ ] Unknown

First prenatal visit date

Month | Day | Year

Check if date unknown □

Demographic Criteria

Circle “T” if factor is present, “F” if it is not and “Unk” if you are unable to determine

Marital status is single, separated, divorced, widowed T F Unk

Late (started after the 12th week of pregnancy) or no prenatal care, poor compliance T F Unk

Inadequate income (TANF or Medicaid, employed without insurance or family financial concerns) T F Unk

Parent is under 21 years of age at time of screen T F Unk

Yes! I would like a Healthy Families Northern Michigan home visitor to contact me.

Yes! If I don’t answer, it is OK to leave a message.

No, I’m not interested in learning more about Healthy Families Northern Michigan.

Parent/Guardian Signature ___________________________ Date ___________________________

Referral Information

□ 1 Private physician
□ 2 Health clinic
□ 3 Hospital
□ 4 WIC
□ 5 WIC

□ 6 Home visiting program
□ 7 Visiting nurse
□ 8 Home health care agency
□ 9 Church

□ 10 School
□ 11 Day care center
□ 12 School
□ 13 Friends/family
□ 14 Door to door outreach

Name of referral source

Screener’s name

First MI Last

Screener’s phone - - -

If returning from an outside agency, please fax signed form to (989) 343-1895.