

# INFANT RISK SCREENING TOOL MATERNAL INFANT HEALTH PROGRAM



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

**Infant Date of Birth:** \_\_\_\_\_

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

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

**City, State, Zip:** \_\_\_\_\_

**Mother/Caregiver:** \_\_\_\_\_

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

**Medical Care Provider**

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

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

**Medicaid Health Plan (OFFICE USE ONLY)** \_\_\_\_\_

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

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

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

**Mom Date of Birth:** \_\_\_\_\_

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

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

**Referral Source:** \_\_\_\_\_

- 1. Need for assistance to care for your infant**  
 Do you have trouble understanding instructions from your Dr.?  Yes\*  No  
 Do you have any experience in taking care of a baby?  Yes  No\*  
 Do you want to learn more about how to take care of your baby?  Yes\*  No  
 Do you have any problems taking care of yourself or your baby?  Yes\*  No  
 Where do you live:  
 Rent apt. or home    Own your home    With relatives  
 Shelter\*    Motel\*    Car\*  
 Do you have trouble reading?  Yes\*  No  
 Is English your first language?  Yes  No\*  
 What is the last grade you finished in school? \_\_\_\_\_  
 Do you need a ride to get to medical appointments?  Yes\*  No  
 How do you get there?  By Car    By Bus/Taxi  
 Other \_\_\_\_\_  
 Have you ever missed a medical appointment because of a ride?  Yes\*  No  
 Do you have a crib or bassinet?  Yes  No\*  
 Do you have a car seat?  Yes  No\*
- 2. Feeding Of Baby**  
 How often do you feed your baby in a day? \_\_\_\_\_  
 Do you:    Breast feed    Bottle feed  
 Are you feeding your baby:  Cereal    Fruits    Vegetables  
 Are you worried about your baby's weight?  Yes\*  No  
 Does your baby have any health problems that worry you?  
 Explain: \_\_\_\_\_
- 3. Mother with cognitive, emotional or mental needs**  
 Do you feel stressed?  Yes\*  No  
 Do you have a history of postpartum depression?  Yes\*  No  
 Are you worried about your mental or emotional health?  Yes\*  No
- 4. Low Birth Weight**  
 What was the birth weight of your baby? \_\_\_\_\_  
 above 5 lbs 5 ounces   or    below 5 lbs 5 ounces  
 What week of the pregnancy was your baby born? \_\_\_\_\_
- 5. Family support**  
 Who can you count on for support?  
 the baby's father?    Yes    No\*  
 a parent?    Yes    No\*  
 a friend?    Yes    No\*  
 Who do you live with? \_\_\_\_\_  
 How many times have you been pregnant? \_\_\_\_\_  
 What are the ages of your children at home? \_\_\_\_\_  
 Who supported you during pregnancy? \_\_\_\_\_
- 6. Homeless/dangerous living situation**  
 Do you/baby feel safe in your home?  Yes    No\*  
 Do you have trouble paying your bills?  Yes\*    No  
 Do you have enough money to buy food?  Yes    No\*
- 7. Family history of mother's abuse/neglect**  
 Do you worry about somebody you know mistreating you?  Yes\*    No  
 Do you worry about anyone you know mistreating your child or children?  Yes\*    No  
 Have you ever been abused?  Yes\*    No  
 Have you ever been neglected?  Yes\*    No
- 8. Use 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

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

Rev 2/07

PLEASE FAX OR MAIL TO PRIORITY HEALTH SERVICES INC.  
 ADDRESS: 11455 E. 13 MILE RD. SUITE 201, WARREN MI. 48093

FAX: 586-979-1185  
 Phone: 1-888-605-2229

Infant's Name \_\_\_\_\_

### INFANT RISK SCREENING TOOL

**10. Is there anything else you want to tell us or that we can help you with? (Explain):**

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

**PATIENT: (Sign here only if you are NOT interested in the program)**

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

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

**MEDICAL or MSS CARE PROVIDER**

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

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

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