



MATERNAL RISK SCREENING TOOL MATERNAL INFANT HEALTH PROGRAM

Patient Name: _____ **Date Of Birth:** _____
 Last First Middle

Due Date: _____

Medicaid ID Number: _____

Address: _____ **Telephone Number:** _____
Patient's Parent/Guardian/Spouse: _____ **Alternate Telephone Number:** _____
Additional Contact Person: _____ **Telephone Number:** _____

Health Care (Obstetrical) Provider
Name: _____ **Telephone Number:** _____

Address: _____

Medicaid Health Plan (OFFICE USE ONLY) _____

- | | |
|--|--|
| <p>1. Need for childbirth education
 Do you know what to expect during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 Do you want to learn more about delivery? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have experience in taking care of a baby? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 Do you want to learn more about how to take care of your baby?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>2. Need for transportation to keep medical appointments
 Do you have a ride to get to medical appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 How do you get there?
 <input type="checkbox"/> By car <input type="checkbox"/> By bus/taxi <input type="checkbox"/> Other _____
 Have you ever missed a medical appointment because of a ride?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>3. Need for assistance to care for your infant
 Do you have trouble reading <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have trouble understanding instructions from your Dr.?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Is English your first language? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 Do you have trouble taking care of yourself physically?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 What is the last grade you finished in school? _____
 Where do you live:
 <input type="checkbox"/> Rent apt. or home <input type="checkbox"/> Own your home <input type="checkbox"/> With relatives
 <input type="checkbox"/> Shelter* <input type="checkbox"/> Motel* <input type="checkbox"/> Car*</p> <p>4. Nutrition/Health problems
 How many meals do you eat per day _____
 Do you skip meals? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you mostly <input type="checkbox"/> Cook at home or eat <input type="checkbox"/> Fast food*
 Which you drink more of?
 <input type="checkbox"/> Pop* <input type="checkbox"/> Juice <input type="checkbox"/> Water <input type="checkbox"/> Milk
 Do have enough money to buy food? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 Is your blood low in iron (anemia)? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have high blood pressure? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have diabetes now or during other pregnancies?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Have you had problems with weight gain or loss during your pregnancy?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have any other health problems that worry you?
 What: _____</p> | <p>5. Family support
 Who can you count on for support?
 The baby's father? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 A parent? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 A friend? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 Who do you live with? _____</p> <p>6. Feelings about current pregnancy
 Have you been pregnant before? <input type="checkbox"/> Yes <input type="checkbox"/> No*
 How many times? _____
 What are your feelings about this pregnancy?
 <input type="checkbox"/> Happy <input type="checkbox"/> Unhappy* <input type="checkbox"/> Don't Know
 Did your last pregnancy result in your baby being born early?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Have you had a death of one of your children before age one?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>7. Mother with cognitive, emotional, or mental needs
 How are you doing overall with taking care of yourself and your child or children?
 <input type="checkbox"/> Good <input type="checkbox"/> Bad* <input type="checkbox"/> O.K.
 Do you feel stressed? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have a history of postpartum depression?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Are you worried about your mental or emotional health?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>8. Social situation
 Do you worry about somebody you know mistreating you?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you worry about anyone you know mistreating your child or children?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you have trouble paying your bills? <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>9. Use of alcohol, drugs or tobacco products
 Do you smoke? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you drink alcohol (beer, wine, liquor) now that you are pregnant?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Do you use street drugs? <input type="checkbox"/> Yes* <input type="checkbox"/> No
 Does someone in your household use street drugs?
 <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> |
|--|--|

A Check/Yes response to any asterisk (*) question indicates automatic referral for MIHP. Rev 3/07

PLEASE FAX OR MAIL TO PRIORITY HEALTH SERVICES INC. FAX: 586-979-1185
 ADDRESS: 11455 E. 13 MILE RD. SUITE 201, WARREN MI. 48093 PHONE: 1-888-605-2229

Patient Name _____

**MATERNAL HEALTH PROGRAM
RISK SCREENING TOOL**

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

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: _____

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