

MATERNAL INFANT HEALTH PROGRAM MATERNAL 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

**Additional Contact
Person:** _____

Telephone: _____

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.