

**Maternal Infant Health Program (MIHP)
Infant Summary For Data Entry**

INSTRUCTIONS

1. Write beneficiary's name, date of birth and Medicaid ID number on each of the lines provided .

The following chart addresses the maternal risk(s) that were identified during infant enrollment in MIHP and current or ongoing maternal risk(s)

These are the domain(s) that are identified at completion of the risk identifier and/or throughout the MIHP care of the pregnant woman	Use the R row for the risk identified at entry into MIHP. Use the S row for the risks that remain at summary and completion of this form Use N for No risk identified ; L for Low risk identified; M for Moderate risk identified ; H for High risk identified and U for Unknown risk identified	Please check all of the boxes that apply to maternal considerations for the duration of the infant's care in MIHP
Interconception Care	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Family Planning Method Identified: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan in Place: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Planning Education Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance Chronic Disease Follow up plan in place <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance
Tobacco: Smoking	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Current: Smokes <input type="checkbox"/> More than 1-1½ packs <input type="checkbox"/> 1 to 1½ packs <input type="checkbox"/> ½ to 1 pack <input type="checkbox"/> 6 to 10 cigarettes <input type="checkbox"/> 1 to 5 cigarettes <input type="checkbox"/> Less than 1 cigarette Education provided: : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Substance Use: Alcohol	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Current: Consumes <input type="checkbox"/> 14 drinks or more a week <input type="checkbox"/> 7 to 13 drinks a week <input type="checkbox"/> 4 to 6 drinks a week <input type="checkbox"/> 1 to 3 drinks a week <input type="checkbox"/> Less than 1 drink a week Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred <input type="checkbox"/> In Treatment
Substance Use: Drugs	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Current status: <input type="checkbox"/> Quit <input type="checkbox"/> Decreased <input type="checkbox"/> Same level <input type="checkbox"/> Increased Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> In Treatment <input type="checkbox"/> Refused Assistance
Stress/Depression/Mental Health	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> In Treatment <input type="checkbox"/> Refused Assistance
Abuse/Violence	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	In Current Domestic Violence Relationship: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance
Basic Needs	R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance

Write the name of the MIHP agency on the line provided
 Type or write your name on the line provided
 Sign your signature on the line provided; include your credentials and date your signature