

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

Beneficiary's Name: _____ Date of Birth: _____ Medicaid #: _____

Infant Services completed? Yes Date: _____ Not completed Cannot be Located

Parent/Guardian Declined Services Reason: _____

Client's MIHP Care Transferred To (Name of MIHP): _____

The following chart addresses the initial risk(s) identified at enrollment in MIHP and current or ongoing risk(s)

Risk /Intervention	Mod/high Risks at Screening	Mod/high Risks at Summary	Progress During Infant Interventions
Infant Health	<input type="checkbox"/>	<input type="checkbox"/>	Seen by medical provider: <input type="checkbox"/> Regularly <input type="checkbox"/> Illness only <input type="checkbox"/> Sporadic Location of medical provider: <input type="checkbox"/> Clinic/office <input type="checkbox"/> ER//Readicare <input type="checkbox"/> Other: _____ WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No CSHCS: <input type="checkbox"/> Yes <input type="checkbox"/> No Immunization up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance
Infant Safety	<input type="checkbox"/>	<input type="checkbox"/>	Sleep: <input type="checkbox"/> Crib <input type="checkbox"/> With someone On back: Yes <input type="checkbox"/> No <input type="checkbox"/> Car seat: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred Lead risk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred 2 nd hand smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No Guns/weapons in home: <input type="checkbox"/> Yes <input type="checkbox"/> No CPS referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Current open case? <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance
Feeding and Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	Infant fed primarily: <input type="checkbox"/> Breastfed <input type="checkbox"/> Bottle <input type="checkbox"/> Solid food Other: _____ Ever breast fed: <input type="checkbox"/> Yes <input type="checkbox"/> No How long: _____ Sleeps with bottle: <input type="checkbox"/> Yes <input type="checkbox"/> No Plans for dentist: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance Referral to WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No Receiving WIC services: <input type="checkbox"/> Yes <input type="checkbox"/> No
Infant Development	<input type="checkbox"/>	<input type="checkbox"/>	Referral to Early On: <input type="checkbox"/> Yes <input type="checkbox"/> No Receiving Early On services: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance
Family Support (Parenting and Childcare)	<input type="checkbox"/>	<input type="checkbox"/>	Can identify minimum of one support person: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred <input type="checkbox"/> Refused Assistance Resources provided: <input type="checkbox"/>

Maternal Considerations

Interconception Care	<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	<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	<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	<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	<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	<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	<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

