

Maternal Infant Health Program (MIHP) Infant Care Communication

Initial Status/Update

Name of MIHP infant beneficiary: _____	Parent or guardian: _____
Physician: _____	Clinic: _____
Birth Date: _____	Date Enrolled in MIHP: _____

Receiving MIHP services Does not qualify for MIHP Declined services Cannot be located

The following risk (s) were identified during the MIHP Infant Risk identifier:

INFANT DOMAIN	RISK	If Risk identified: MIHP Provider Comments	Follow Up Requested by Medical Provider
Infant Health	<input type="checkbox"/>		
Infant Safety	<input type="checkbox"/>		
Feeding and Nutrition	<input type="checkbox"/>		
General Development	<input type="checkbox"/>		
Family Support (Parenting and Childcare)	<input type="checkbox"/>		

Family, Living Arrangement, Language and Environmental Considerations:

Below is a brief description of key interventions, significant change(s) and referral(s) for the risk factor(s) listed above.

Signature: _____ Date: _____

Detailed MIHP Plan of Care is available for this beneficiary upon request.

