Maternal Infant Health Program (MIHP) Prenatal Communication

☐ **Initial** ☐ **Status/Update**

Name of MIHP beneficiary: _____ Physician_____

Birth Date:_____ Clinic:_____

Date Enrolled in MIHP:_____ EDC:_____

Receiving MIHP services ☐ Does not qualify for MIHP ☐ Declined services ☐ Cannot be located ☐ Other _____

Current Living Situation: ☐ On Own ☐ W/Relative(s) ☐ W/Father of Baby ☐ W/Friend ☐ At Shelter ☐ Other
Additional issues: ☐ CPS involvement ☐ Concerned about comprehension ☐ Language barrier

The following risk (s) were identified during the MIHP screening and assessment:

MATERNAL DOMAIN	RISK	MIHP Provider Comments	Follow Up Requested by Medical Provider
Health History / Risks (Family Planning)	☐		
Health History /Risks (Pregnancy History) Prenatal Care	☐		
Basic Needs (Food)	☐		
Basic Needs (Housing)	☐		
Basic Needs (Transportation)	☐		
Social Support	☐		
Tobacco: Smoking	☐		
Tobacco: 2nd Hand Smoke	☐		
Substance Use: Alcohol	☐		
Substance Use: Drugs	☐		
Stress/Depression/Mental Health	☐		
Abuse/Violence	☐		
Health History / Risks Chronic Disease: Asthma	☐		
Health History / Risks Chronic Disease: Diabetes	☐		
Health History / Risks Chronic Disease: Hypertension	☐		

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