

SCREENING DATE			
<u>MM</u>	<u>DD</u>	<u>YY</u>	

PROVIDER ID# / PROVIDER NAME	

I-1	IDENTIFICATION/DEMOGRAPHIC INFO
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1.1 MOTHER'S IDENTIFICATION			
NAME			
FIRST			↓
MI			
LAST			
1.1A	MEDICAID ID#		↓
1.1B	SOCIAL SECURITY#		↓
		-	
		-	
1.1C	What is your date of birth?		
*			→
	<u>MM</u>	<u>DD</u>	
	REFUSED		

1.2 INFANT'S IDENTIFICATION			
NAME			
FIRST			↓
MI			
LAST			
1.2A	MEDICAID ID#		↓
1.2B	SOCIAL SECURITY#		↓
		-	
		-	
1.2C	What is your baby's date of birth?		
			↓
	<u>MM</u>	<u>DD</u>	
	REFUSED		

I-2 **INFANT HEALTH STATUS**

2.1 **What was your baby's expected due date?**

<input type="text"/>	<input type="text"/>	<input type="text"/>	↓
MM	DD	YY	
<input type="checkbox"/> REFUSED			

2.5 **How much does your baby weigh now?**

<input type="text"/>	<input type="text"/>	↓
Pounds	Ounces	
<input type="checkbox"/> UNKNOWN		

2.2 **What was your baby's gestational age at birth?**

* < 37 Weeks

<input type="text"/>	Weeks	↓
<i>Note: calculate from expected due date and actual date of Birth information if unknown</i>		

2.6 **What is your baby's height (length) now?**

<input type="text"/>	Inches	↓
<input type="checkbox"/> UNKNOWN		

2.3 **How much did your baby weigh at birth?**

* < 5.5 Pounds

<input type="text"/>	<input type="text"/>	↓
Pounds	Ounces	
<input type="checkbox"/> UNKNOWN		

2.7 **Was this baby delivered by vaginal birth or C-section?**

<input type="checkbox"/> Vaginal	↓
<input type="checkbox"/> C-Section	

2.4 **What was your baby's height (length) at birth?**

<input type="text"/>	Inches	→
<input type="checkbox"/> UNKNOWN		

2.8 **Did your baby stay in the hospital after you went home?**

<input type="checkbox"/> No	2.11 ↓
<input type="checkbox"/> Yes	↓

2.9 **How long did your baby stay in the hospital? (fill in one)**

<input type="text"/>	Days	↓
<input type="text"/>	Weeks	
<input type="text"/>	Months	

2.10 **What was the reason for the stay?**

<input type="text"/>	↓
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2.11 **Since coming home from the hospital, has your baby been seen by a doctor for problems he had in the hospital?**

<input type="checkbox"/> Yes	↓
<input type="checkbox"/> No	

2.12 **Has your baby had any new health problems since coming home from the hospital?**

<input type="checkbox"/>

<input type="checkbox"/>	* Yes	↓ 2.13 →
<input type="checkbox"/>	No	

If **YES**, please explain:

2.13	Has your baby been diagnosed with any birth defects (congenital anomalies, etc)?	
<input type="checkbox"/>	* Yes	↓ 3.1 ↓
<input type="checkbox"/>	No	

If **YES**, please explain:

I-3	INFANT HEALTH CARE
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3.1	How old was your baby when he/she was first seen by a healthcare provider?	
	<input style="width: 50px;" type="text"/> Weeks	↓
<input type="checkbox"/>	* My baby hasn't been seen by a healthcare provider yet	
<input type="checkbox"/>	REFUSED	

3.2	Where do you usually take your baby for health care?	
<input type="checkbox"/>	Doctor's office	↓
<input type="checkbox"/>	Public health clinic	
<input type="checkbox"/>	Readicare facility	
<input type="checkbox"/>	* Hospital	
<input type="checkbox"/>	* Emergency room	
<input type="checkbox"/>	Other _____	
<input type="checkbox"/>	* Nowhere	
<input type="checkbox"/>	REFUSED	

3.3	Has your baby been seen by a healthcare provider other than the one you mentioned above?	
<input type="checkbox"/>	Yes	3.3A ↓
<input type="checkbox"/>	No	3.4 ↓

3.3A	Who?	
<input type="checkbox"/>	Doctor's office	↓
<input type="checkbox"/>	Public health clinic	
<input type="checkbox"/>	Readicare facility	
<input type="checkbox"/>	* Hospital	
<input type="checkbox"/>	* Emergency room	
<input type="checkbox"/>	Other _____	
<input type="checkbox"/>	REFUSED	

3.3B	What was the reason?	
<input type="checkbox"/>	<input style="width: 100%; height: 20px;" type="text"/>	↓

3.4	Here is a list of problems some women can have getting health care for their infants. For each item, please let us know if it has been true for you at any time since the birth of your baby. [READ LIST]	
<input type="checkbox"/>	* I couldn't get an appointment when I wanted one	➔
<input type="checkbox"/>	* I couldn't find a doctor or clinic that accepted Medicaid	
<input type="checkbox"/>	* It is hard to communicate with the doctor or clinic staff	
<input type="checkbox"/>	* It is hard to understand the information the doctor or clinic give to me	
<input type="checkbox"/>	* I haven't had enough money or insurance to pay for my visits	
<input type="checkbox"/>	* I've had no way to get to the clinic or doctor's office	
<input type="checkbox"/>	* I couldn't take time off from work	
<input type="checkbox"/>	* I've had no one to take care of my other children	
<input type="checkbox"/>	* I have had too many other things going on in my life	
<input type="checkbox"/>	* Other. Please tell us:	
<input type="checkbox"/>	REFUSED	

3.5 Is your baby currently enrolled in WIC?		
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	* No	

3.6 Is your baby currently enrolled in Children's Special Health Care Services (CSHCS)?		
<input type="checkbox"/>	* Yes	↓
<input type="checkbox"/>	No	

3.7 Did your baby receive a Hepatitis B immunization before leaving the hospital?		
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
<input type="checkbox"/>	Don't Know	

3.8 Is your baby up to date on immunizations?		
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
<input type="checkbox"/>	Don't Know	

I-4	INFANT SAFETY
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4.1 Where does your baby usually sleep?		
<input type="checkbox"/>	Crib	↓
<input type="checkbox"/>	* In bed with someone	
<input type="checkbox"/>	* On floor	
<input type="checkbox"/>	In car seat	
<input type="checkbox"/>	Other:	

4.3 In what position do you usually lie your infant down to sleep?		
<input type="checkbox"/>	* Front	↓
<input type="checkbox"/>	Back	
<input type="checkbox"/>	* Side	

4.2 How often does your newborn sleep in the same bed with you or someone else?		
<input type="checkbox"/>	Never	➔
<input type="checkbox"/>	* Sometimes	
<input type="checkbox"/>	* Most or every night	

4.4 Do you have a car seat for the baby?		
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	* No	

4.5	Do you live in or regularly visit a house that was built before 1978 or that has peeling or chipped paint?	
	* Yes	↓
	No	

4.6	What type of water is used for drinking in your household?	
	City water	↓
	Bottled water	
	Well water	
	Don't know	

4.7	Do you smoke around the baby (in the same room, same house, same car)?	
	Yes	↓
	No	

4.8	Is there a smoker in the home or someone that regularly visits that smokes?	
	Yes	↓
	No	

4.9	Is there someone in the home or someone who regularly visits that gets drunk around your baby?	
	Yes	↓
	No	

4.10	Does anyone in your home own a gun or other weapon?	
	No	4.11 →
	Yes	4.10A ↓

		YES	NO	
4.10A	Is the gun loaded?			→
4.10B	Is the ammunition kept with or near the gun?			
4.10C	Is the weapon locked up?			
4.10D	Have you considered getting rid of the gun/weapon for the safety of your child?			

4.11	Are you a first time parent?	
	Yes	4.13 ↓
	No	4.12 ↓

4.12	Have you ever been involved with Children's Protective Services with any of your children?	
	No	4.13 ↓
	* Yes	4.12A →
	REFUSED	

4.12A	What was the result?	
	* Out of home placement	4.13 ↓
	Court-mandated counseling	
	Intensive at-home services	
	Nothing but talking with them	
	Other Specify _____	
	REFUSED	

4.13	Are you afraid of anyone in your household who may hurt your baby?	
	Yes	4.13A ↓
	No	5.1 ↓
	REFUSED	

4.13A	If yes, who?	
	Father of the baby	5.1 ↓
	Partner	
	Roommate	
	Other family member	
	Specify _____	
	REFUSED	

I-5 **INFANT FEEDING AND NUTRITION**

5.1 How do you primarily feed your baby?

<input type="checkbox"/>	Breastfeeding	5.3 ↓
<input type="checkbox"/>	Formula	↓
<input type="checkbox"/>	Solid Foods	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Any Concerns? Please explain:	

5.5A If yes:

At what age did your baby start taking formula?	<input type="text"/>	↓
What is the name of your baby's formula?	<input type="text"/>	
How often does your baby eat?	<input type="text"/>	
How many ounces?	<input type="text"/>	

5.2A Have you ever breastfed your baby?

<input type="checkbox"/>	Yes	5.2B ↓
<input type="checkbox"/>	No	5.4 ↓

5.6 Do you hold your baby while you feed him/her a bottle?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	* No	

5.2B Are you breastfeeding now?

<input type="checkbox"/>	No	5.4 ↓
<input type="checkbox"/>	Yes	5.3 ↓
If yes, how many times every 24 hours?		<input type="text"/>

5.7 Does your baby receive anything else in the bottle besides formula or breast milk?

<input type="checkbox"/>	No	5.8 ↓
<input type="checkbox"/>	Yes	5.7A ↓

5.3 If you are returning to work/school, do you have a plan to help you continue to breastfeed?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

5.7A What?

<input type="checkbox"/>	Cereal	↓
<input type="checkbox"/>	* Soda	
<input type="checkbox"/>	* Sugar water	
<input type="checkbox"/>	* Kool-aid/fruit drinks	
<input type="checkbox"/>	Juice	
<input type="checkbox"/>	* Herbal Teas	
<input type="checkbox"/>	Other:	

5.4 Have you ever bottle fed your baby?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

5.8 At what age do you plan to introduce solid foods to your baby?

<input type="text"/>	Months	↓
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5.5 Has your baby ever received formula?

<input type="checkbox"/>	Yes	5.5A →
<input type="checkbox"/>	No	5.6 →

5.9	In the past month, how often has your child gone to bed with a bottle of juice, formula, milk, or any liquid besides water?	
<input type="checkbox"/>	* Often	➔
<input type="checkbox"/>	* Sometimes	
<input type="checkbox"/>	Rarely	
<input type="checkbox"/>	Never	

5.10	At what age do you plan to first take your baby to the dentist?		Years	↓
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5.11	Do you currently have any concerns or worries about how to care for your child's teeth?		↓
<input type="checkbox"/>	No		
<input type="checkbox"/>	Yes		

INSTRUCTIONS: please proceed to the developmental section corresponding to the infant/toddler's age, as outlined in the tables below:

IF INFANT/TODDLER AGE IS	Bright Futures
Less than 3 weeks	BF0
3 to 4 weeks	BF1
1 month 0 days to 2 months 30 days	BF2
3 months 0 days to 4 months 30 days	BF4
5 months 0 days to 7 months 30 days	BF6
8 months 0 days to 10 months 30 days	BF9
11 months 0 days to 12 months 30 days	BF12
13 months 0 days to 15 months 30 days`	BF15

BF0	GENERAL INFANT DEVELOPMENT - Newborn Less than 3 weeks				
	Item	Yes	Some- times	Not Yet	Not Sure
	1. Does your baby respond to sound (for example, by blinking, crying, quieting, changing respiration, or showing a startle response)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	2. Does your baby focus on your face and follow it with his/her eyes?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	3. Does your baby look at you and respond to your voice?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	4. Does your baby lift his/her head momentarily?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	5. Can your baby move his/her arms, legs and head?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF1	GENERAL INFANT DEVELOPMENT - Newborn 3 to 4 weeks				
	Item	Yes	Some- times	Not Yet	Not Sure
	1. Does your baby respond to sound (for example, by blinking, crying, quieting, changing respiration, or showing a startle response)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	2. Does your baby focus on your face and follow it with his/her eyes?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	3. Does your baby look at you and respond to your voice?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	4. Is your baby's body generally relaxed?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	5. Can your baby move his/her arms, legs and head?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	6. When lying on his/her tummy, can your baby lift his/her head momentarily?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	7. When your baby is crying, can he/she be consoled most of the time by being spoken to or held?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
	8. Does your baby cry, coo, and smile?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF2	GENERAL INFANT DEVELOPMENT – 2 Months 1 month 0 days to 2 months 30 days			
<u>Item</u>	Yes	Some- times	Not Yet	Not Sure
1. If you copy the sounds your baby makes, does your baby repeat the sounds back to you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your baby seem to pay attention to voices around him/her?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your baby show an interest in sounds and moving objects?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. When you smile at your baby, does he/she smile back at you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Does your baby seem to enjoy interacting with you and with other people that take care of him/her?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. When lying on his/her tummy, can your baby lift his/her head, neck, and upper chest by using his/her forearms for support?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. When your baby is in an upright position, can he/she control his/her head sometimes?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF4	GENERAL INFANT DEVELOPMENT – 4 Months 3 months 0 days to 4 months 30 days			
<u>Item</u>	Yes	Some- times	Not Yet	Not Sure
1. Does your baby smile and laugh?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your baby interact with you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your baby have different cries for different needs (eg. hungry, wet, tired)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. Does your baby like to look at and be with you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Does your baby show you what he/she likes?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. Does your baby babble (eg. “aaa”, “eee”, “ooo”)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. Does your baby have good head control?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
8. Does your baby move both sides of his/her body equally?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
9. Does your baby push his/her chest up when on his/her tummy?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
10. Does your baby bat at objects?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
11. Does your baby roll or try to roll from tummy to back?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF6	GENERAL INFANT DEVELOPMENT – 6 Months 5 months 0 days to 7 months 30 days			
<u>Item</u>	Yes	Some- times	Not Yet	Not Sure
1. Does your baby smile, laugh, squeal?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your baby recognize familiar faces?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your baby enjoy taking turns “talking” with you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. Does your baby string sounds together (babbling “ah”, “oh”, “dada”, “baba”)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Is your baby beginning to recognize his/her name?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. Can your baby sit with support?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. Can your baby roll over?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
8. Can your baby stand and bear weight when held in that position?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
9. Does your baby mouth objects he/she is interested in?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
10. Does your baby shake, bang, throw and drop objects/toys?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF9	GENERAL INFANT DEVELOPMENT – 9 Months 8 months 0 days to 10 months 30 days			
<u>Item</u>	Yes	Some- times	Not Yet	Not Sure
1. Has your baby developed concern about strangers?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your baby seek you for play and comfort?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your baby use a wide variety of sounds (babbling, “mama”, “dada”)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. Is your child starting to point out objects?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Does your baby know that an object still exists if it is hidden or out of their sight?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. Does your baby play games like “pee-a-boo” and “pat-a-cake”?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. Is your baby crawling?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
8. Does your baby sit without help?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
9. Does your baby move him/herself into a sitting position?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
10. Does your baby pull him/herself to a standing position?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
11. Does your baby feed him/herself food with his/her fingers?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF12	GENERAL INFANT DEVELOPMENT – 12 Months 11 months 0 days to 12 months 30 days			
<u>Item</u>	Yes	Some-	Not Yet	Not Sure

10/09 Michigan Maternal Infant Health Program
 Postnatal Risk Screening: **INFANT COMPONENT** (Modified)

		times		
1. Does your baby play games like “pee-a-boo” and “so big”?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your baby repeat a game or activity that they see you or another child do?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your baby wave “bye-bye”?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. Does your baby get upset when you leave him/her?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Does your baby point at a desired object and watch to see if you see it?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. Does your baby use one to two words (eg. “mama”, “dada”)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. Does your baby jabber as if he/she is talking?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
8. Does your baby follow simple requests (eg. “give me the ball”)?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
9. Does your baby stand alone?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
10. Does your baby bang two blocks together?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
11. Does your baby eat a variety of foods?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

BF15	GENERAL TODDLER DEVELOPMENT – 15 Months 13 months 0 days to 15 months 30 days			
<u>Item</u>	Yes	Some- times	Not Yet	Not Sure
1. Does your toddler listen to a story?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
2. Does your toddler pretend to feed a doll a bottle or move cars/trucks around?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
3. Does your toddler show you what he/she wants by pulling, pointing or grunting?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
4. Does your toddler bring you things to show you?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
5. Does your toddler say 2-3 words (other than “mama” or “dada”) and use them correctly?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
6. Does your toddler understand and follow simple commands?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
7. Does your toddler scribble?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
8. Does your toddler walk well, stoop/squat, and then, stand again?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
9. Does your toddler crawl down steps backwards?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
10. Does your toddler stack two blocks?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>
11. Does your toddler feed himself/herself with fingers/spoon and drink from a cup?	<input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>	<input type="checkbox"/>

Throughout this risk-screening form, an asterisk (*) was placed next to the responses that if checked by the beneficiary would indicate they have risk. If a beneficiary checks, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for Maternal Infant Health Program (MIHP). Completion of an ASQ and ASQ-SE assessment corresponding to the infant’s age is also recommended. In the event none of the beneficiary’s answers on this form are marked by an asterisk, they may still be assessed based on the MIHP provider’s judgment.

MIHP Postnatal Risk Factor Eligibility Screening Form completed by:

Signature

Discipline

Date