

**Maternal Infant Health Program (MIHP)  
Maternal Summary**

Name of Medical Care Provider/Clinic: \_\_\_\_\_

Beneficiary's Name: \_\_\_\_\_ Date Maternal Risk Identifier completed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ EDC: \_\_\_\_\_ Delivery Date: \_\_\_\_\_

Number prenatal visits: \_\_\_\_\_ Number of postpartum visits: \_\_\_\_\_ Infant followed in MIHP:  Yes  No

Maternal Services completed?  Yes Prior to Birth  Yes After Birth Date Completed: \_\_\_\_\_  No  Declined Services

Why? \_\_\_\_\_  Cannot be Located  Moved To: \_\_\_\_\_

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)**

<b>Risk /Intervention</b>	<b>Mod/high Risks at Screening</b>	<b>Mod/high Risks at Summary</b>	<b>Progress During Maternal Interventions</b>
Health History / Risks (Family Planning)	<input type="checkbox"/>	<input type="checkbox"/>	Method Identified: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan for use in place: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Health History /Risks (Pregnancy History) Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	Started: <input type="checkbox"/> Prior to 14 weeks <input type="checkbox"/> At or beyond 14 weeks
Basic Needs (Food)	<input type="checkbox"/>	<input type="checkbox"/>	Food: Adequate <input type="checkbox"/> Yes <input type="checkbox"/> No Nutrition Risks addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Basic Needs (Housing)	<input type="checkbox"/>	<input type="checkbox"/>	Stable: <input type="checkbox"/> Yes <input type="checkbox"/> No Safe: <input type="checkbox"/> Yes <input type="checkbox"/> No Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Basic Needs (Transportation)	<input type="checkbox"/>	<input type="checkbox"/>	Adequate: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Social Support	<input type="checkbox"/>	<input type="checkbox"/>	Can identify a 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"/> Refused Assistance <input type="checkbox"/> Referred
Tobacco: Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<b>During pregnancy:</b> Smoked <input type="checkbox"/> More than 1- 1½ packs <input type="checkbox"/> 1 to 1 ½ 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 <b>Current:</b> 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"/>	<b>During pregnancy:</b> Consumed <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 <b>Current:</b> 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"/>	<b>During pregnancy:</b> <input type="checkbox"/> Quit <input type="checkbox"/> Decreased <input type="checkbox"/> Same level <input type="checkbox"/> Increased <b>Current status:</b> <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"/> Refused Assistance <input type="checkbox"/> Referred <input type="checkbox"/> In Treatment
Stress/Depression/Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred <input type="checkbox"/> In Treatment
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"/> Refused Assistance <input type="checkbox"/> Referred

**Maternal Infant Health Program (MIHP)**

**Maternal Summary**

Health History / Risks Chronic Disease: Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Health History / Risks Chronic Disease: Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred
Health History / Risks Chronic Disease: Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Assistance <input type="checkbox"/> Referred

Child Birth Education:  Provided  Referred  Refused    Attended?  Yes  No  Unknown

Achieved Recommended Prenatal Weight?  Yes  No  Unknown    If No:  Over  Under

Breastfeeding?  Yes  No  Unknown     Education provided  Refused Assistance  Referred

Infants Gestation Age:  ≤ 37 Weeks  >37 Weeks

Infant's Birth Weight:

Immunization Schedule:  Education Provided  Referred  Refused    Well Child Schedule :  Education Provided  Referred  Refused

Referrals Made During Care:  Family Planning  Plan FIRST!  Immunization  Medical  Dental  Counseling  Substance Abuse Treatment

Domestic Violence Services  Child Protective Services (CPS)  Parenting Support  WIC  Basic Needs  Child care  Baby Items  Education

Employment  Home Visitation/Support Program  Describe: \_\_\_\_\_

Other: \_\_\_\_\_

**Additional Comments:**

MIHP Agency: \_\_\_\_\_

Name (print or type): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_