

## PRENATAL COMMUNICATION

Michigan Department of Health and Human Services  
Maternal Infant Health Program

Name of MIHP Beneficiary	Beneficiary Birthdate	Beneficiary Phone Number	
Beneficiary Address	City	State	Zip Code
Medical Care Provider or Clinic	Medicaid Health Plan <input type="checkbox"/> FFS*		
Name of MIHP	MIHP Case Manager Phone Number		
EDD	Date Enrolled in MIHP		

### RISK IDENTIFIER SCORE SUMMARY

Maternal Domain	Risk	MIHP Provider Comments	Follow Up Requested
Family Planning	<input type="checkbox"/>		Please fax back to MIHP if follow up is requested.
Pregnancy Health	<input type="checkbox"/>		
Medical Considerations	<input type="checkbox"/>		
Breastfeeding	<input type="checkbox"/>		
Tobacco	<input type="checkbox"/>		
Alcohol	<input type="checkbox"/>		
Substance Misuse	<input type="checkbox"/>		
Stress/Depression	<input type="checkbox"/>		
Social Support	<input type="checkbox"/>		
Abuse/Violence	<input type="checkbox"/>		
Housing	<input type="checkbox"/>		
Food/Nutrition	<input type="checkbox"/>		
Transportation	<input type="checkbox"/>		

### COMMENTS

Signature	Credentials	Date
<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>		

# PRENATAL COMMUNICATION INSTRUCTIONS

These instructions are intended to clarify data fields. If you have additional questions, please contact the MDHHS MIHP Team.

## Prenatal Communication

- Medical Care Provider or Clinic: Insert name of an individual or of a medical care practice.
- Name of MIHP: Insert the name of your MIHP.
- MIHP Case Manager Phone Number: Insert agency phone number or number of case manager assigned to this beneficiary.
- Beneficiary Phone Number: Insert beneficiary's most recent phone number.
- Beneficiary Address: Insert beneficiary's most recent address.
- Medicaid Health Plan or FFS: Insert the name of the beneficiary's MHP. If beneficiary is not enrolled in an MHP, check the FFS box. If the beneficiary has not received an ID number, write application pending in the MHP space.
- Beneficiary Birth Date: Insert beneficiary's date of birth.
- EDD (estimated date of delivery): Insert due date.

## Risk Identifier Score Summary

- Checkbox Column: Check the box next to every domain that has been identified by the Risk Identifier or by professional observation and judgment (in keeping with the criteria in Column 2 of the POC 2 for a given domain). Do not check any box for any domain that has not been identified for the beneficiary.
- MIHP Provider Comments: Insert any information with respect to a given domain that may be helpful for the medical care provider. This is not a required field.
- Follow-up Requested by Medical Care Provider: Leave this column blank. It is for use by the medical care provider to indicate any actions he or she would like you to take based on the information you have provided on this form.
- Comments: This box at the bottom of the form is provided so you can add any other comments that may be helpful for the medical care provider, such as key interventions, significant changes and referrals for any or all of the identified domains. This is not a required field.
- Signature and Credentials: This field pertains only to the RN or SW who completes this form. It may not be signed by any other office staff.

**Note:** Send the Prenatal Communication Form to the beneficiary's medical care provider.