# Maternal Risk Identifier Worksheet

## Demographics

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Date</td>
<td></td>
</tr>
<tr>
<td>Medicaid ID</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>M.I.</td>
<td></td>
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<tr>
<td>Legal Last Name</td>
<td></td>
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<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Female/Male</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married/Unmarried/Widowed/Separated/Divorced/Refused</td>
</tr>
<tr>
<td>City</td>
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<td>County</td>
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## Basics (1 of 2)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Language</td>
<td>English/Spanish/Arabic/Other</td>
</tr>
<tr>
<td>How well do you speak English?</td>
<td>Very Well/Not well/Well/Not at all</td>
</tr>
<tr>
<td>Deaf or serious difficulty hearing</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Blind or serious difficulty seeing</td>
<td>Yes/No</td>
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<tr>
<td>Serious difficulty concentrating, remembering, making decisions</td>
<td>Yes/No</td>
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<tr>
<td>Serious difficulty walking or climbing stairs</td>
<td>Yes/No</td>
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<tr>
<td>Difficulty reading</td>
<td>Yes/No</td>
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<tr>
<td>Difficulty doing errands alone</td>
<td>Yes/No</td>
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<tr>
<td>Currently work outside the home?</td>
<td>Yes/No</td>
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<tr>
<td>Hours worked in typical week</td>
<td></td>
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<tr>
<td>Planning to work in near future</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Currently attending school?</td>
<td>Yes/No</td>
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</tbody>
</table>
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How many grades of school have you completed?
☐ Less than 8th
☐ Junior High/Middle School
☐ High School Diploma/GED
☐ Associate’s Degree
☐ Bachelor’s Degree
☐ Graduate Degree
☐ Trade School

Where do you reside?
☐ House
☐ Apartment
☐ Mobile Home
☐ Shelter
☐ Group Home
☐ Homeless
☐ Other If other, selected, please explain: __________________________

Do you live alone? ☐ Yes ☐ No

Basics (2 of 2) Household Members

If Mother does not live alone, please enter who she lives with.

Member in Household:

What is their relationship to you?

<table>
<thead>
<tr>
<th>What is their relationship to you?</th>
<th>What is their First Name? (optional)</th>
<th>Last Name? (optional)</th>
</tr>
</thead>
<tbody>
<tr>
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Health History Pregnancy

What was your weight just before you became pregnant? __________________ lbs. ☐ Don’t Know
What is your weight now? __________________ lbs. ☐ Don’t Know
What is your height without shoes? __________________ Feet __________________ Inches ☐ Don’t Know

Including this pregnancy, how many times have you been pregnant? __________________ (count abortions, miscarriages or stillbirths)

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When did your last pregnancy end? (delivery, abortion, miscarriage or stillbirth) (MM/YYYY)

<table>
<thead>
<tr>
<th>Did any of your pregnancies end in:</th>
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<tbody>
<tr>
<td>Miscarriage in the 4th month of pregnancy or later?</td>
</tr>
<tr>
<td>Stillbirth</td>
</tr>
<tr>
<td>Baby weighing less than 5.5 lbs. at birth?</td>
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<tr>
<td>Baby born more than 3 weeks early (did anyone</td>
</tr>
<tr>
<td>Tell you that your baby was premature/preterm)?</td>
</tr>
<tr>
<td>Baby that stayed in the hospital after you went home?</td>
</tr>
<tr>
<td>Baby weighed 9 lbs. or more?</td>
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<tr>
<td>Baby born with congenital or other birth defects?</td>
</tr>
<tr>
<td>Baby born but died before one year of age?</td>
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</tbody>
</table>

Do you have a history of pregnancy complications? □ Yes □ No

If yes, what were the complications?

Have you ever taken a childbirth education class? □ Yes □ No

### Health History, Hypertension, Asthma, Diabetes

Have you ever been treated or told that you have:

- High Blood Pressure (hypertension)? □ Yes □ No
  (If No, go to Asthma questions)
- Are you currently under care for this condition? □ Yes □ No
- Do you have a visit scheduled? □ Yes □ No
- Have you been in the hospital or ER for this problem in the last six months? □ Yes □ No

- Asthma? □ Yes □ No
  (If No, go to Diabetes questions)
- Are you currently under care for this condition? □ Yes □ No
- Do you have a visit scheduled? □ Yes □ No
- Have you been in the hospital or ER for this problem in the last six months? □ Yes □ No

- Diabetes or high blood sugar? □ Yes □ No
  (If No, go to STI questions)
- What type? 1, 2 or gestational? □
- Are you currently under care for this condition? □ Yes □ No
- Do you have a visit scheduled? □ Yes □ No
- Have you been in the hospital or ER for this problem in the last six months? □ Yes □ No

Comments:

### Health History HIV/ Sexually Transmitted Infection

Have you ever been treated or told that you have:

- Sexually transmitted infection? □ Yes □ No
  (If No, go to HIV questions)

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If yes, check all that apply:
- Gonorrhea
- Syphilis
- Chlamydia
- Herpes
- Hepatitis B
- Genital Warts
- HPV
- Parasites
- Cancroid
- Trichomoniasis

Are you currently under care for this condition? □Yes □No
Is it treatable or chronic? □Treatable □Chronic
Do you have a visit scheduled? □Yes □No
Have you been in the hospital or ER for this problem in the last six months? □Yes □No

HIV Positive?
(If No, go to Anemia questions)
Are you currently under care for this condition? □Yes □No
Do you have a visit scheduled? □Yes □No
Have you been in the hospital or ER for this problem in the last six months? □Yes □No

Comments:

Health History Other

Have you ever been treated or told that you have:

Anemia?
Are you currently under care for this condition? □Yes □No
Do you have a visit scheduled? □Yes □No
Have you been in the hospital or ER for this problem in the last six months? □Yes □No

Sickle Cell?
Are you currently under care for this condition? □Yes □No
Do you have a visit scheduled? □Yes □No
Have you been in the hospital or ER for this problem in the last six months? □Yes □No

Any other condition you see a doctor for? □Yes □No
If Yes, Explain: 
Are you currently under care for this condition? □Yes □No
Do you have a visit scheduled? □Yes □No
Have you been in the hospital or ER for this problem in the last six months? □Yes □No

Are you taking prescription drugs? □Yes □No
If yes, what prescription drugs are you taking?

How long has it been since you had a dental exam or cleaning?
- Within the past year
- Within the past 2 years
- Within the past 5 years
- More than 5 years ago
- Don’t know/not sure
- Never

In the past year, have you noticed any problems with your teeth or gums such as bad breath that will not go away, loose or sensitive teeth, or gums that are red and swollen, tender or bleeding? □Yes □No

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**Family Planning**

- **When was your last menstrual period?**
  - [ ] (MM/YYYY) 
  - [ ] Don’t Know

- **When is your baby due?**
  - [ ] (MM/DD/YYYY) 
  - [ ] Don’t Know

- **How do you feel about becoming pregnant?**
  - [ ] Wanted to be pregnant sooner
  - [ ] Wanted to be pregnant later
  - [ ] Wanted to be pregnant now
  - [ ] Not wanting to be pregnant now or at any time in the future
  - [ ] Don’t Know
  - [ ] Refused

- **At the time when you became pregnant were you using birth control?**
  - [ ] Yes
  - [ ] No
  - [ ] Don’t know

- **What is your history of birth control use?**
  - [ ] None
  - [ ] Intermittent
  - [ ] Consistent

- **Do you intend to use birth control post pregnancy?**
  - [ ] Yes
  - [ ] No
  - [ ] Don’t know

**Prenatal Care**

- **How many weeks pregnant were you when you had your first visit for prenatal care?**
  - [ ] weeks

- **Do you have an appointment scheduled?**
  - [ ] Yes
  - [ ] No

- **When you have a health issue or problem, where do you usually go for care?**

  - [ ] Doctor’s office
  - [ ] Public Health Clinic
  - [ ] Urgent Care
  - [ ] Hospital Clinic
  - [ ] Emergency Room
  - [ ] OB Provider

  - Name of doctor or clinic
  - Name of doctor or clinic
  - Name of doctor or clinic
  - Name of doctor or clinic
  - Name of doctor or clinic
  - Name of doctor or clinic

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Other: [ ]
Nowhere: [ ]
If Other, Specify: __________________________

Have you had any difficulty getting the prenatal care you want or need?  [ ] Yes  [ ] No
If yes, please check each item that is true for this pregnancy (check all that apply)

☐ OB provider won’t schedule an appointment until the end of the first trimester
☐ OB provider refused to schedule an appointment because my pregnancy is advanced
  If advanced pregnancy, # of weeks: __________________ weeks
☐ I couldn’t get an appointment when I wanted one
☐ I couldn’t find a doctor or clinic that accepted Medicaid
☐ It is hard to communicate with the doctor or clinic staff
☐ It is hard to understand the information the doctor or clinic gives me
☐ I haven’t had enough money or insurance to pay for my visits
☐ I haven’t had my Medicaid card or presumptive eligibility printout after applying for Medicaid online
☐ I have no way to get to the clinic or doctor’s office
☐ I couldn’t take time off work
☐ I had no one to take care of my children
☐ I have had too many other things going on in my life
☐ I didn’t want anyone to know I was pregnant
☐ Other: __________________________

Comments: __________________________

Nutrition (1 of 2)

For this pregnancy (check all that apply)

☐ Some weight loss during pregnancy
☐ Severe nausea and vomiting
☐ Gestational diabetes mellitus
☐ Expecting to deliver twins or more
☐ Fetal growth restriction
☐ None

Have you taken any vitamins or minerals in the past month?  [ ] Yes  [ ] No  [ ] Unknown

Do you take any of the following?  [ ] Iron pills  [ ] Supplements (Boost, Ensure, etc.)  [ ] Vitamin water  [ ] None

Do you have any food allergies?  [ ] Yes  [ ] No
If Yes, what are you allergic to? __________________________

Do you eat or drink any of the following every day or most days? (Check all that apply)

☐ Sweet or salty snacks
☐ Whole grains
☐ Coffee/Tea
☐ Raw sprouts
☐ Refrigerated pate or meat spreads or refrigerated smoked seafood
☐ Pop or other sweetened beverages
☐ Fruits and vegetables
☐ Artificial sweeteners (Splenda, Aspartame, Equal, Sweet n Low)
☐ Raw or undercooked (rare) meat, fish, poultry or eggs
☐ Raw or undercooked tofu
☐ Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot
☐ Milk (whole, 2%, skim)
☐ Energy drinks
☐ Raw (unpasteurized) juice or milk
☐ Soft cheese (feta, camembert, brie, queso blanco, queso fresco, Panela)
☐ Michigan fish
☐ None

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Nutrition (2 of 2)

Do you or have you (Check all that apply):
- Eat a strict vegetarian or vegan diet
- Eat a low calorie/weight loss diet
- Had bariatric surgery
- Eat a low-carbohydrate, high protein diet (like Atkins, etc.)
- Eat little food because of stomach surgery to lose weight
- Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry or corn starch)
- Take an iodine supplement daily
- Take a fluoride supplement
- Take a vitamin or mineral supplement daily  What kind? ______________________
- Use herbal supplement or remedies or teas  What kind? ______________________
- None

Have you ever had an eating disorder?  ☐ Yes  ☐ No  ☐ Refused
If Yes, explain: ____________________________________________________________

Do you have any other dietary problems?  ☐ Yes  ☐ No  ☐ Refused
If yes, explain: ____________________________________________________________

Comments: __________________________________________________________________

Breastfeeding

Which of the following best describes your thoughts on breastfeeding your new baby?
- I know I will breastfeed
- I think I might breastfeed
- I know I will not breastfeed
- I don’t know what to do about breastfeeding
- Refused

Have you ever breastfed any other children?  ☐ Yes  ☐ No
If No, skip next 3 questions

Have you had an unsuccessful breastfeeding experience?  ☐ Yes  ☐ No

How long did you breastfeed with last pregnancy?
- Less than 2 weeks
- 2 weeks–1 month (30 days)
- 2-6 months
- Greater than 6 months

Are you currently breastfeeding another child?  ☐ Yes  ☐ No

Do you have access to a breast pump at home?  ☐ Yes  ☐ No

Do you know how to access a lactation consultant or breastfeeding support?  ☐ Yes  ☐ No

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Comments:

Smoking

Which of the following statements would you say best describes your cigarette smoking?

☒ I wasn’t smoking around the time I found out I was pregnant, and I don’t currently smoke cigarettes
☒ I have quit smoking since finding out I was pregnant
☒ I smoke every once in a while
☒ I smoke regularly now, but I’ve cut down since I found out I was pregnant
☒ I smoke regularly now – about the same amount as before finding out I was pregnant
☒ Refused

If 1st box is checked or refused, skip to smokeless tobacco question
If 2nd box is checked, skips questions “Have you seriously thought” and “Have you tried to quit”

How many cigarettes do/did you smoke on an average day?

☒ More than 1-1 ½ packs
☒ 1-1 ½ packs
☒ ½ to 1 pack
☒ 6 to 10 cigarettes
☒ 1 to 5 cigarettes
☒ Less than 1 cigarette

How soon after you wake up do/did you smoke your first cigarette?

☒ Within 5 minutes
☒ 6-30 minutes
☒ 31 minutes or more

Which cigarette would/did you MOST hate to give up?  ☐ First cigarette in the morning  ☐ Any others

Do/did you find it difficult to stop smoking in non-smoking areas?  ☐ Yes  ☐ No

Do/did you smoke MORE FREQUENTLY in the first hours after waking in the morning than the rest of the day?  ☐ Yes  ☐ No

Do/did you some if you are so ill that you are in bed most of the day?  ☐ Yes  ☐ No

Have you made any other changes or gotten any support to make it easier for you not to smoke?  ☐ Yes  ☐ No

Have you seriously thought about quitting smoking during this pregnancy?  ☐ Yes  ☐ No

Have you tried to quit smoking in the last 30 days?  ☐ Yes  ☐ No

Do you use smokeless tobacco?  ☐ Yes  ☐ No

Is there a smoker in the home?  ☐ Yes  ☐ No

Is there someone who regularly visits that smokes?  ☐ Yes  ☐ No

Will you be somewhere where the baby is exposed to smoke?  ☐ Yes  ☐ No

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What is your plan to avoid smoke exposure to the baby?

Comments:

Alcohol

Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers?

- I drink alcohol regularly now – about the same as before finding out I was pregnant
- I drink alcohol regularly now but I’ve cut down since I found out I was pregnant
- I drink alcohol every once in a while
- I have quit drinking alcohol since I found out I was pregnant
- I wasn’t drinking alcohol around the time I found out I was pregnant and I don’t currently drink (If this response is checked skip all other alcohol questions)
- Refused

Approximately how many alcoholic drinks do you have in an average week/or did when drinking?

- 14 drinks or more a week
- 7 to 13 drinks a week
- 4 to 6 drinks a week
- 1 to 3 drinks a week
- None
- Refused

How many times do you drink or did you, when you were drinking, consume 5 alcoholic drinks or more in one sitting since becoming pregnant?

- 6 or more
- 4 to 5 times
- 2 to 3 times
- 1 time
- I don’t have 5 drinks or more in one sitting
- Refused

How many drinks does it/did take to make you feel high?

- 1
- 2
- 3 or more
- Refused

Have people annoyed you by criticizing your drinking? □Yes □No □Refused

Have you ever felt you ought to cut down on your drinking? □Yes □No □Refused

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □Yes □No □Refused

Have you seriously thought about quitting all alcohol during this pregnancy? □Yes □No □Refused

Have you tried to quit drinking alcohol in the last 30 days? □Yes □No □Refused

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Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?  □ Yes  □ No  □ Refused

Are you in treatment?  □ Yes  □ No  □ Refused

Comments:

**Drug Use**

Does your partner or anyone in your household use drugs?  □ Yes  □ No  □ Refused

If Yes, who: ______________________

If Yes, what do they use? (check all that apply). If No, skip to next question.

- □ Marijuana
- □ Crack
- □ Heroin
- □ Downers
- □ Diet Pills
- □ PCP
- □ Cocaine
- □ Uppers/Crank/Meth/Speed
- □ LSD/Mushrooms
- □ Prescription drugs not prescribed for you
- □ Methadone/Subutex/Suboxone
- □ Other: ______________________

During the month BEFORE you knew you were pregnant, did you use any drugs or diet pills?  □ Yes  □ No  □ Refused

If Yes, what did you use? (check all that apply). If No, skip to next question.

- □ Marijuana
- □ Crack
- □ Heroin
- □ Downers
- □ Diet Pills
- □ PCP
- □ Cocaine
- □ Uppers/Crank/Meth/Speed
- □ LSD/Mushrooms
- □ Prescription drugs not prescribed for you
- □ Methadone/Subutex/Suboxone
- □ Other: ______________________

Since learning you were pregnant, did you use drugs or diet pills?  □ Yes  □ No  □ Refused

If Yes, what did you use? (check all that apply). If No, skip to next question.

- □ Marijuana
- □ Crack
- □ Heroin
- □ Downers
- □ Diet Pills
- □ PCP
- □ Cocaine
- □ Uppers/Crank/Meth/Speed
- □ LSD/Mushrooms
- □ Prescription drugs not prescribed for you
- □ Methadone/Subutex/Suboxone
- □ Other: ______________________

If still using drugs:

Have you seriously thought about quitting all drugs during this pregnancy?  □ Yes  □ No  □ Refused

Have you tried to quit using drugs in the last 30 days?  □ Yes  □ No  □ Refused

Have you made any changes or gotten any supports to make it easier for you to not use drugs?  □ Yes  □ No  □ Refused

Are you in treatment?  □ Yes  □ No  □ Refused

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Comments:

Stress

In the last month, how often have you felt that you were unable to control the important things in your life?

☐ Never (0) ☐ Almost Never (1) ☐ Sometimes (2) ☐ Fairly Often (3) ☐ Very often (4)

In the last month, how often have you felt confident about your ability to handle your personal problems?

☐ Never (4) ☐ Almost Never (3) ☐ Sometimes (2) ☐ Fairly Often (1) ☐ Very often (0)

In the past month, how often have you felt that things were going your way?

☐ Never (4) ☐ Almost Never (3) ☐ Sometimes (2) ☐ Fairly Often (1) ☐ Very often (0)

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

☐ Never (0) ☐ Almost Never (1) ☐ Sometimes (2) ☐ Fairly Often (3) ☐ Very often (4)

Comments:

Higher score, higher the stress

Depression and Mental Health

Have you ever been treated for or told that you have a mental health concern? ☐ Yes ☐ No ☐ Refused

If Yes, please check all that apply; (If No or Refused, skip to the section below titled, “Depression Follow-up Screening”)

☐ Depression ☐ Bipolar Disorder

☐ Schizophrenia ☐ Anxiety ☐ Other

When did you last see a health care provider about this concern? ________________ (MM/ YYYY)

Do you have a visit scheduled? ☐ Yes ☐ No ☐ Refused

Have you been in the hospital or ER for this condition in the last six months? ☐ Yes ☐ No ☐ Refused

I’d like to ask you some follow-up questions about how you’re feeling. I’m going to read some statements and responses. For each statement, please let me know which response is the closest to how you’ve been in the past 7 days.

I have been able to laugh and see the funny side of things:

☐ As much as I always could (0)
☐ Not quite so much now (1)
☐ Definitely not so much now (2)
☐ Not at all (3)
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I have looked forward with enjoyment to things:
☐ As much as I ever did (0)
☐ Rather less than I used to (1)
☐ Definitely less than I use to (2)
☐ Hardly at all (3)

I have blamed myself unnecessarily when things went wrong:
☐ Yes, most of the time (3)
☐ Yes, some of the time (2)
☐ Not very often (1)
☐ No, never (0)

I have been anxious or worried for no good reason:
☐ No, not at all (0)
☐ Hardly ever (1)
☐ Yes, sometimes (2)
☐ Yes, very often (3)

I have felt scared or panicky for no good reason:
☐ Yes, quite a lot (3)
☐ Yes, sometimes (2)
☐ No, not much (1)
☐ No, not at all (0)

Things have been getting on top of me:
☐ Yes, most of the time I haven't been able to cope at all (3)
☐ Yes, sometimes I haven't been coping as well as usual (2)
☐ No, most of the time I have coped quite well (1)
☐ No, I have been coping as well as ever (0)

I have been so unhappy that I have had difficulty sleeping
☐ Yes, most of the time (3)
☐ Yes, sometimes (2)
☐ Not very often (1)
☐ No, not at all (0)

I have felt sad or miserable:
☐ Yes, most of the time (3)
☐ Yes, quite often (2)
☐ Not very often (1)
☐ No, not at all (0)

I have been so unhappy that I have been crying:
☐ Yes, most of the time (3)
☐ Yes, quite often (2)
☐ Only occasionally (1)
☐ No, never (0)

The thought of harming myself has occurred to me:
☐ Yes, quite often (3)
☐ Sometimes (2)
☐ Hardly ever (1)
☐ Never (0)

Maximum score: 30 possible. Always look at last question (Suicidal thoughts)
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Comments:

Social Support

Would you describe the father of this baby as?
- Involved in my pregnancy and supportive of me
- Involved but not supportive of me
- Aware that I’m pregnant but not involved
- Not aware that I am pregnant
- Refused

Is there someone you can count on to help you during this pregnancy and with your new baby?  □ Yes  □ No
If Yes, continue on to next question
If No, skip to the following question.

Who do you count on for support? (check all that apply)
- Current Partner
- Ex-partner
- Parent(s)
- Friend(s)
- Neighbor(s)
- Other relative(s)
- Other

Are you involved in any support group(s) or other resources?  □ Yes  □ No  □ Sometimes
If Yes, which groups or resources?

Comments:

Abuse and Violence

Are you in a relationship right now?  □ Yes  □ No  □ Refused
If Yes, do you feel safe in your present relationship?  □ Yes  □ No  □ Refused
If No or Refused, skip to the next question.

Within the last year, have you been hit, kicked, slapped or otherwise physically hurt by someone?  □ Yes  □ No  □ Refused
If yes, by whom? (Select all that apply)  If No or Refused, skip to the next question.

Current Partner  □ Yes  □ No  □ Refused
Ex-Partner  □ Yes  □ No  □ Refused
Stranger  □ Yes  □ No  □ Refused
Family member  □ Yes  □ No  □ Refused  If Yes, specify __________
Others  □ Yes  □ No  □ Refused  If Yes, specify __________
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How many times has this happened?  □ Once  □ More Than Once  □ Refused

Since becoming pregnant, have you been hit, kicked, slapped or otherwise physically hurt by someone?  □ Yes  □ No  □ Refused

By whom? (Select all that apply)
- Current Partner  □ Yes  □ No  □ Refused
- Ex-Partner  □ Yes  □ No  □ Refused
- Stranger  □ Yes  □ No  □ Refused
- Family member  □ Yes  □ No  □ Refused  If Yes, specify  
- Others  □ Yes  □ No  □ Refused  If yes, specify  

How many times has this happened?  □ Once  □ More Than Once  □ Refused

Has your partner or someone else in your life?  Question Refused  □ Yes  □ No

Select all that apply:
- Called you names, humiliated you, or made you feel that you don’t count?  □ Yes  □ No  □ Refused
- Kept you from seeing or talking to your family, friends, or other people?  □ Yes  □ No  □ Refused
- Thrown away or destroyed your belongings, threatened pets, or done things to bully or scare you?  □ Yes  □ No  □ Refused
- Controlled your use of money, access to money or your ability to work?  □ Yes  □ No  □ Refused

Has anyone forced you to have sexual activities?  □ Yes  □ No  □ Refused

If Yes, by whom? (Select all that apply) If No or refused, skip to the next question
- Current Partner  □ Yes  □ No  □ Refused
- Ex-Partner  □ Yes  □ No  □ Refused
- Stranger  □ Yes  □ No  □ Refused
- Family member  □ Yes  □ No  □ Refused  If Yes, specify  
- Others  □ Yes  □ No  □ Refused  If Yes, specify  

How many times has this happened?  □ Once  □ More Than Once  □ Refused

Within the past year, have you felt pressured to have sexual activities?  □ Yes  □ No  □ Refused

By whom? (Select all that apply)
- Current Partner  □ Yes  □ No  □ Refused
- Ex-Partner  □ Yes  □ No  □ Refused
- Stranger  □ Yes  □ No  □ Refused
- Family member  □ Yes  □ No  □ Refused  If Yes, specify  
- Others  □ Yes  □ No  □ Refused  If Yes, specify  

How many times has this happened?  □ Once  □ More Than Once  □ Refused

Have you been emotionally, physically or sexually abused by your partner or someone important to you?  □ Yes  □ No  □ Refused

Are you afraid of your partner or anyone listed above?  □ Yes  □ No  □ Refused

As a child have you ever been involved with Children’s Protective Services?  □ Yes  □ No  □ Refused

If yes, were you in the custody of Children’s Protective Services?  □ Yes  □ No  □ Refused

MRI Worksheet
Have you ever been involved with Children’s Protective Services with any of your children?  
☐ Yes ☐ No ☐ Refused

What was the result? (Select all that apply)  
☐ Out of home placement  ☐ Yes ☐ No ☐ Refused  
☐ Intensive at-home services  ☐ Yes ☐ No ☐ Refused  
☐ Court mandated placement  ☐ Yes ☐ No ☐ Refused  
☐ Nothing but talking with them  ☐ Yes ☐ No ☐ Refused  
☐ Other  ☐ Yes ☐ No ☐ Refused

If Other, specify: __________________________

Comments:

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**Basic Needs – Housing**

How many times have you moved in the last 12 months?  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Are you homeless?  ☐ Yes ☐ No ☐ Refused

If Yes, where do you stay at night?  __________________________

Do you currently have any concerns or worries about your housing situation?  ☐ Yes ☐ No

If Yes, check all that apply. If No, skip to the next question.

☐ No place to live, no regular nighttime residence  ☐ Eviction or being forced to move out
☐ Affordability of current house or apartment  ☐ Strained relations with others in household
☐ House or apartment is too crowded  ☐ Safety of house/apartment
☐ Safety of neighborhood  ☐ Sanitation/waste removal
☐ Code violations  ☐ Pest control
☐ Ventilation/air conditioning  ☐ Ease of access into home
☐ Lack of continuous functioning basic utility service (e.g., heat, electricity)

Do you have difficulty paying bills?  ☐ Yes ☐ No ☐ Refused

Which ones?  _________________________________________  Are you at risk for a utility shut off?  ☐ Yes ☐ No

Do you have access to the following?  

☐ A working refrigerator?  ☐ Yes ☐ No  
☐ A working stove?  ☐ Yes ☐ No  
☐ Clean running water?  ☐ Yes ☐ No

If No to clean water, what do you use for drinking water?  _________________________________________

Do you have working smoke detectors in the house?  ☐ Yes ☐ No
Do you live in a house built before 1978?  
☐Yes  ☐No

Do you or others in your household have an occupation that involves lead exposure?  
☐Yes  ☐No

Do you live in an old house with ongoing renovations that generate a lot of dust (e.g., sanding and scraping)?  
☐Yes  ☐No

To your knowledge, has your home been tested for lead in the water?  
If yes, were you told that the lead level was high?  
☐Yes  ☐No

Do you use any traditional folk remedies or cosmetics that are not sold in a regular drug store or are homemade, which may contain lead?  
☐Yes  ☐No

Do you or others in your household have any hobbies or activities likely to cause lead exposure?  
☐Yes  ☐No

Do you use non-commercially prepared pottery or leaded crystal?  
☐Yes  ☐No

Comments:

Basic Needs – Food/Transportation

Food
In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there was not enough money for food?  
☐Yes  ☐No  ☐Refused

If yes, how often did this happen?  
☐Almost every month  ☐Some months but not very much  ☐In only 1 or 2 months

Are you using WIC, SOM Food Assistance Program or other Food Assistance such as Food Pantries, Commodities or Churches?  
☐Yes  ☐No

Transportation

Do you have access to routine transportation?  
If No, please check all concerns that apply:  ☐Potential unavailability  ☐Unreliable  ☐Not affordable
If Yes, skip to the next question.

Do you know how to get transportation assistance through your Medicaid Health Plan?  
☐Yes  ☐No

Do you have a way to make appointments or access emergency assistance?  
☐Yes  ☐No  ☐Sometimes

What is the best way to get ahold of you?  
☐Phone  ☐Text message  ☐Email  ☐Letter  ☐Other  If Other, explain:

Is there anything else you need as you prepare for your baby to come home?

MRI Worksheet
Maternal Risk Identifier Worksheet

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☐ I agree that, to the best of my knowledge, the information submitted for this Screening is correct.