INFANT SUMMARY
Infant Basic Demographics

Exit application

Beneficiary Name: **Medicaid Id:** **SSN: --** **Date of Birth:**

Parent/Guardian First/Last Name:

IRI Completed On:

Number of Visits:

IBCLC Visits: 0

Infant Services:

Enrolled in WIC: ○ Yes ○ No

Receiving Children's Special Health Services (CSHCS): ○ Yes ○ No

Immunizations Up to Date: ○ Yes ○ No

Sleeps in Crib, Play Yard, or Bassinet: ○ Yes ○ No

Sleeps on Back: ○ Yes ○ No

Sleeps with Someone: ○ Yes ○ No

Breastfeeding Initiated:

Breastfeeding Duration:

Identify at Least 1 Support Person: ○ Yes ○ No

Family Planning Method Identified: ○ Yes ○ No

Family Planning Method in Place: ○ Yes ○ No

Currently Breastfeeding:

Developmental Risk Identified: ○ Yes ○ No

Early On Referral Made: ○ Yes ○ No

Followed Through with Referral: ○ Yes ○ No

Save | Save/Next | Clear | Cancel