

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT RISK SCREEN**

Research supports the fact that low income mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health. The risk screen is designed to identify high risk infants as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____
Parent/Guardian Name _____
Client's Address _____ Phone # _____

A. MEDICAL RISKS

- | | | | |
|----------|--|----------|--|
| 1. _____ | Diagnosed developmentally delayed/
neurologically impaired | 6. _____ | Medical high risk infant and pediatric care needed,
but not available 24 hours a day |
| 2. _____ | Diagnosed medically significant genetic
condition (including sickle cell disease) | 7. _____ | Medical condition(s) the severity of which
requires care coordination (document medical
condition below) |
| 3. _____ | Birth weight 1750 grams (3 lbs., 14 oz.), or less | 8. _____ | Born exposed to an illegal drug |
| 4. _____ | Chronic illness | 9. _____ | Failure to thrive or flattening of growth curve |
| 5. _____ | Diagnosed with fetal alcohol syndrome (FAS) | | |

B. SOCIAL RISKS

- | | | | |
|----------|--|----------|--|
| 1. _____ | Parent/guardian unable to communicate due to
language barriers (e.g. non-English speaking,
illiterate) | 6. _____ | Shelter, homeless or migrant worker |
| 2. _____ | Maternal absence (illness, incarceration
abandonment) | 7. _____ | Mother 18 years or younger |
| 3. _____ | Parental substance abuse/addiction (only
include father if living in home) | 8. _____ | History of suspected abuse/or neglect |
| 4. _____ | Caregiver's handicap presents risk to infant
(physically impaired, hearing impaired, vision impaired) | 9. _____ | Non compliant with follow-up visits/screening
visits and medical direction for <u>this infant</u> |
| 5. _____ | Caregiver mental illness/mental retardation | | |

C. NUTRITIONAL RISKS

- | | | | |
|----------|---|----------|-----------------|
| 1. _____ | Congenital abnormalities affecting ability to feed or requiring special
feeding techniques; poor sucking, severe or continuing diarrhea or vomiting;
other conditions requiring diet modification | 2. _____ | Inadequate diet |
|----------|---|----------|-----------------|

- REFERRAL:** 1. _____ Care Coordination
 _____ No Care Coordination
 2. _____ What services will the recipient receive? _____

PROVIDER COMMENTS/SUGGESTIONS:

PROVIDER'S SIGNATURE & TITLE _____ SCREENING DATE _____
NAME AND TITLE PRINTED _____ NATIONAL PROVIDER IDENTIFIER:

REFERRAL TO HIGH-RISK CARE COORDINATION