VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. National Provider Identifier: _ _ _ _ _ _ _ _ _ _
7. Race: 1. White 2. Black 3 American Indian. 4. Asian 5. Hispanic 6. Other ☐			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter the infant's birth weight and Apgar scores:

A. Birth weight: lbs _____ oz. _____ B. Apgar: 1 min. _____ 5 min _____

12. Enter reason infant is no longer receiving care coordination services: ☐ Date closed: _____

1 - reached age two
2 - dropped out of well-child care
3 - transfer to other MICC agency
4 - lost to follow-up
5 - eligibility cancelled
6 - problem resolved
7 - died
8 - moved
9 - other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death: ☐

1 - accident 2 - congenital abnormality 3 - birth trauma 4 - non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy: ☐

16. Enter number of week gestation when mother began care: ☐

17. Indicate if mother received care coordination services during this pregnancy: ☐

1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two: ☐

1 – normal health & development 2 – developmentally delayed
3 – congenital abnormality 4 – non-congenital disease

19. Enter child's living situation at age two: ☐

1 – with parent/guardian 2 – foster care placement 3 – long term care facility

20. Enter total number of EPSDT visits during first two years: ☐

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No ☐

22. Enter child's height and weight at age two:

Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs

Instructions: Indicate needs that were met through care coordinator assistance by entering **"Y" (yes**) in the appropriate block(s). Indicate clients needs that were not met at the completion of care coordination services by entering **"N" (no)** in the appropriate block(s):

☐ 1. child care ☐ 4. nutrition counseling ☐ 7. employment ☐ 10. job training
☐ 2. food stamps ☐ 5. parenting education ☐ 8. counseling ☐ 11. transportation
☐ 3. housing ☐ 6. home health services ☐ 9. school enrollment

_____ _____
Coordinator's Signature Date

DMAS-54 RVSD 032307