INFANT RISK SCREEN

Use ink. Be certain to check the appropriate boxes at the top of the birth certificate.

Pursuant to § 383.14(1)(b) and 383.011(1)(e), F.S., this form must be completed for each infant and submitted to the local County Health Department, Office of Vital Statistics.

MOTHER

Mother's Name: First Last Maiden

Mother's Date of Birth

INFANT

Infant's Name: First Last | Infant's Date of Birth | Boy | Girl

Name of Infant's Doctor/ HMO or Group: _____ Name of birth hospital/facility: _____

Was the infant transferred? ❑ No ❑ Yes If Yes, enter name of facility transferred to: _____

Was the infant admitted to neonatal intensive care unit for more than 24 hours? ❑ No ❑ Yes ❑ Unknown

SECTION 1: COMPLETED BY PATIENT

Yes_____ **No**_____ **(please initial)** I am interested in having my infant screened for risks that could affect his/her health or development in the first year of life.

Yes_____ **No**_____ **(please initial)** If my infant is referred, Healthy Start may contact me.

I can be reached at (home phone): _____ or (work or contact phone): _____

Street Address: _____

(Give either street address with bldg.#, apt.# or lot# or directions to baby's home)

Mailing Address: _____

(if different from street address)

Yes_____ **No**_____ **(please initial)** By initialing yes, I am giving my written permission on behalf of my infant for release of the confidential information on this form and any information provided during his/her evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization shall remain in effect unless withdrawn in writing.

_____ _____

Signature of parent or guardian **Date (mo/day/yr)**

SECTION 2: BY PROVIDER

Item numbers correspond to the numbers on the Birth Certificate. Write the point(s) on the appropriate lines, and add for the total score.

Item 54	④____	Abnormal conditions include one or more of the following: Assisted Ventilation (30 min. or more), Assisted Ventilation (6 hrs. or more), NICU admission, newborn given Surfactant Replacement Therapy, Hyaline Membrane Disease/RDS, or seizure or serious neurological dysfunction.
Item 4	④____	Birthweight less than 2000 grams or less than 4 pounds, 7 ounces
Item 28b	④____	Infant transferred within 24 hours of delivery
Item 15	①____	Mother unmarried
Item 26	①____	Principal source of payment Medicaid
Item 30	①____	Maternal race black
Item 19	①____	Father's name not present or unknown
Item 40	①____	Mother used tobacco in one or more trimesters
Item 36d	①____	Prenatal visits less than 2 or unknown
Item 16	①____	Maternal age less than 18 or unknown

_____ **Infant's Healthy Start Screening Score**

CHECK ONE

❑ **Referred to Healthy Start**
If score less than 4 specify reason for referral:_____

❑ **Not referred to Healthy Start**

BE CERTAIN TO CHECK THE APPROPRIATE BOXES AT THE TOP OF THE BIRTH CERTIFICATE.

I have explained the Healthy Start program, and if screened, the patient's screening score.

_____ _____

Provider's/Interviewer's Signature and Title **Date (mo/day/yr)**

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

Please complete information about the mother and infant at the top of the form even if the mother is not interested in having infant screened. Be certain to check the appropriate boxes at the top of the birth certificate. Use ink.

Healthy Start helps moms find needed services to help reduce the risk of a sickly baby.
Healthy Families Florida promotes positive parenting and healthy child development.

FIRST STEP - SECTION 1 Parent or Guardian

1. Please indicate screening consent by writing initials next to **yes** or **no**. Please sign name at the bottom of section 1.
2. Please indicate program consent and release of information consent by initialing next to **yes** or **no**. **Remember you must sign name at the bottom of section 1.**

SECOND STEP - SECTION 2 Provider or Interviewer

1. There are 10 items on the birth certificate used in determining the Healthy Start screening score. Those items are numbers 54, 4, 28b, 15, 26, 30, 19, 40, 36d and 16. The numbers circled below indicate the point(s) assigned to each item response. Please write the points on the appropriate line on the front of the form.
2. Add the marked points. This total is the Infant's Healthy Start Screening Score. Put this total in the appropriate space at the bottom of Section 2.
3. **Refer the infant to participate in Healthy Start Care Coordination if** (a) the infant screening score is four or more, or (b) the infant is at risk for an adverse outcome based on factors other than score, including maternal illness, homelessness, domestic violence, substance abuse, or other factors that Healthy Start care coordination or risk appropriate care might reduce.
4. Indicate referred or not referred in the appropriate spaces in Section 2.
5. Provider/Interviewer places signature, title and date at the bottom of Section 2. **Be certain to check the appropriate boxes at the top of the birth certificate.**

Number 54 ④
If abnormal conditions include one or more of the following: Assisted ventilation required (30 minutes or more), Assisted Ventilation (6 hrs. or more), NICU admission, newborn given Surfactant Replacement Therapy, Hyaline Membrane Disease/RDS, or seizure or serious neurological dysfunction.

Number 4 ④
If the infant's birth weight is less than 2000 grams or less than 4 pounds, 7 ounces.

Number 28b ④
If infant transferred within 24 hours of delivery.

Number 15 ①
If the mother is not married

Number 26 ①
If principal source of payment is Medicaid

Number 30 ①
If maternal race is black.

Number 19 ①
If father's name is not present or is unknown.

Number 40 ①
If Mother used tobacco in one or more trimesters.

Number 36d ①
Prenatal visits less than 2 or is unknown

Number 16 ①
If maternal age is less than 18 or is unknown

Shelter, counseling, and legal aid are available to families experiencing violence. Call 1-800 500-1119
For substance abuse treatment, call the Family Health Line at 1-800-451-2229
WIC provides pregnant women and children with healthy foods! Call 1-800-342-3556