HS-FS ADDENDUM TO INFANT RISK IDENTIFER-INFANT COMPONENT

HSID:_ _ _ _ -_ _ _ _ -_ _ Date: (mm/dd/yyyy)_____ Staff:_____

Location of visit: ☐ Home ☐Office ☐ Other

Child's First Name: _____Child's Last Name:_____

MIHP Client: ☐ Yes ☐ No

· Change Client Contact Information (update if needed)
Current Address:_____ Phone_____ · None
City:_____State_____ Zip Code_____ County_____

Did the woman that gave birth to this child participate in healthy start-family spirit while pregnant with this child (Prenatally Enrolled)? ☐ Yes ☐ No ☐ Unknown

Child's Current Age: _____

Infant delivered as: ☐ Singleton ☐ Twin ☐ Triplet or more

Delivery Course: ☐ Spontaneous ☐ Scheduled ☐ Unknown

If scheduled, was it: ☐ Elective ☐ Non-elective # of weeks gestation:_____

Primary Insurance Coverage ☐ Medicaid ☐ MI-Child ☐Private ☐ None

Medical Home: ☐ Yes ☐ No

Has infant/Child been diagnosed with:

Asthma. ☐ Yes ☐ No ☐ REFUSED

HIV/AIDS ☐ Yes ☐ No ☐ REFUSED

Infant Drug Screen Status:
☐ Screen done – positive ☐ Screen done – negative ☐ Screen Not Done/Unknown