# Infant Risk Identifier Worksheet

## Demographics

### Infant Demographic Information

Screening Date _____ (MM/DD/YYYY) Medicaid ID _____

First Name _____ M.I. _____ Legal Last Name _____ Sex ☐Female ☐Male

City _____ County _____

What is your infant's date of birth? _____ (MM/DD/YYYY)

### Caregiver Demographic Information

**Non-Traditional Caregiver** ☐Foster ☐Other

Medicaid ID _____

First Name _____ M.I. _____ Legal Last Name _____ Sex ☐ Female ☐ Male

City _____ County _____

What is your date of birth? _____ (MMDDYYYY) What is your marital status? ☐Married ☐Unmarried
☐Widowed ☐Separated
☐Divorced ☐Refused

## Maternal/Infant Basics

### Infant Basic Information

Infant's age at time of Risk Identifier

- ☐ Less than 3 weeks
- ☐ 3 to 4 weeks
- ☐ 1 month 0 days to 2 months 30 days
- ☐ 3 months 0 days to 4 months 30 days
- ☐ 5 months 0 days to 7 months 30 days
- ☐ 8 months 0 days to 10 months 30 days
- ☐11 months 0 days to 12 months 30 days
- ☐13 months 0 days to 15 months 30 days

What do you identify as the infant's race/ethnic background? (check all that apply)

- ☐Asian
- ☐American Indian or Alaskan Native
- ☐Black or African American
- ☐Native Hawaiian or other Pacific Islander
- ☐White/Caucasian
- ☐Arab/Chaldean
- ☐Hispanic/Latino
- ☐Refused

### Maternal Basic Information

Mother's age at time of birth _____ Years ☐ Don't Know

How many grades of school have you completed?

- ☐Less than 8th
- ☐Jr. high/middle school
- ☐Trade school
- ☐High school diploma/GED
- ☐Associate degree
- ☐Bachelor's degree
- ☐Graduate degree

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## Infant Family Support, Parenting and Childcare

Do you have any problems finding or paying for reliable child care? ☐Yes ☐No

Would you describe the father of this baby as

- ☐Involved in the baby's life and supportive of the baby
- ☐Involved in the baby's life but not supportive'
- ☐Aware of the baby but not involved with us
- ☐Unaware that he is the father
- ☐Refused
- ☐Don't Know

Is there someone in your life you can count on to help you with the baby? ☐ Yes ☐ No

Who spends the most time with your baby?

- ☐I do
- ☐My partner or baby's father
- ☐My parent(s) or the father's parents
- ☐Other
- ☐My other children
- ☐My friend(s)/neighbor(s)
- ☐Day care staff

Are you a first-time parent? ☐Yes ☐No

If No:

How many sibling children? ☐

Comments ☐

## Infant Birth Health Status

What was your baby's expected due date? ☐ (MM/DD/YYYY) ☐Don't Know

What was your baby's gestational age at birth? ☐ Weeks ☐Don't Know

**Note: calculate from expected due date and actual date of birth information if unknown.**

How much did your baby weigh at birth? ☐ lbs. ☐ oz. ☐Don't Know

Did your baby stay in the hospital after you went home? ☐Yes ☐No ☐Don't Know

How long did your baby stay in the hospital? ☐ Days

What was the reason for the stay? ☐

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Has your baby had any new health problems since coming home from the hospital? ☐Yes ☐No

If Yes: please explain

Were you told that the baby needed an additional hearing test? ☐Yes ☐No ☐Don't Know

If Yes: please explain

Did the baby have the additional test? ☐Yes ☐No

If Yes, what was the result

If No

☐Didn't have transportation ☐Didn't know who to call

☐Didn't feel it was important ☐Didn't understand what you needed to do

☐Physician/ medical care provider said to wait ☐Other Explain:

Were you told that the baby needed any follow-up to the heel poke (Newborn screening) test done at the hospital? ☐Yes ☐No ☐Don't Know

If Yes: please explain

Did the follow-up testing or appointment occur? ☐Yes ☐No

If Yes, what was the result

If No

☐Didn't feel it was important ☐Didn't understand what you needed to do

☐Didn't know who to call ☐Didn't have transportation

☐Physician/ medical care provider said to wait ☐Other Explain:

Comments

## Infant Health Care

How old was your baby when he/she was first seen by their family doctor (sometimes called a medical home)?

Weeks Days

☐ My baby hasn't been seen by a family doctor and we don't have an appointment.
☐ My baby hasn't been seen by a family doctor and has an appointment.
☐ Refused

Has your baby been seen by a healthcare provider other then the family doctor (medical home) mentioned above?

☐Yes ☐No

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Here is a list of problems some women can have getting health care for their infants. For each item, please let us know if it has been true for you at any time since the birth of your baby. [READ LIST] (check all that apply)

- ☐ I couldn't get an appointment when I wanted one
- ☐ I couldn't find a doctor or clinic that accepted Medicaid
- ☐ It is hard to communicate with the doctor or clinic staff
- ☐ It is hard to understand the information the doctor or clinic gave to me
- ☐ I haven't had enough money or insurance to pay for my visits
- ☐ I've had no way to get to the clinic or doctor's office
- ☐ I couldn't take time off from work
- ☐ I've had no one to take care of my other children
- ☐ I have had too many other things going on in my life
- ☐ Other, please tell us
- ☐ None
- ☐ Refused

Is your baby currently enrolled in Children's Special Health Services (CSHCS)? ☐Yes ☐No

Did your baby receive a Hepatitis B immunization before leaving the hospital? ☐Yes ☐No

Is your baby up to date on immunizations? ☐Yes ☐No ☐Don't Know

Comments

## Infant Safety

Where does your baby usually sleep?

☐Crib ☐In bed with someone ☐On floor ☐Bassinette ☐In a car seat ☐Other Explain:

How often does your newborn sleep in the same bed with you or someone else?

☐Never ☐Sometimes ☐Most or every night

In what position do you usually lie your infant down to sleep? ☐Front ☐Back ☐Side

When your baby is upset, what do you do to quiet him or her?

Do you have a car seat for the baby? ☐Yes ☐No

Do you smoke around the baby (the same room, same house, same car)? ☐Yes ☐No

Is there a smoker in the home or someone that regularly visits that smokes? ☐Yes ☐No

Is there someone in the home or someone who regularly visits that gets drunk around your baby? ☐Yes ☐No

Are you afraid you or anyone in your household may hurt your baby? ☐Yes ☐No ☐Refused

# Infant Risk Identifier Worksheet

Comments

## Infant Feeding and Nutrition

What do you primarily feed your baby?

Have you ever breastfed your baby? ☐Yes ☐No

Is your baby currently enrolled in WIC? ☐Yes ☐No

Do you hold your baby when feeding him or her—including feeding with a bottle? ☐Yes ☐No

Does your baby receive anything else in the bottle besides formula or breast milk? ☐Yes ☐No

In the past month, how often has your child gone to bed with a bottle of juice, formula, milk or other liquid besides water?
☐Often ☐Sometimes ☐Rarely ☐Never

Comments

## General Infant Development

INSTRUCTIONS: Please proceed to the developmental section corresponding to the infant/ toddler's age, as outlined in the tables below:

| IF INFANT/ TODDLER AGE IS | Bright Futures |
|---|---|
| Less than 3 weeks | BF 0* |
| 3 to 4 weeks | BF 1* |
| 1 month 0 days to 2 months 30 days | BF 2* |
| 3 months 0 days to 4 months 30 days | BF 4** |
| 5 months 0 days to 7 months 30 days | BF 6** |
| 8 months 0 days to 10 months 30 days | BF 9** |
| 11 months 0 days to 12 months 30 days | BF 12** |
| 13 months 0 days to 15 months 30 days | BF 15** |

* If the infant is less than **two months old and at least one Bright Futures "not yet" box is checked,** administer the ASQ-3 within two weeks. If the infant is less than one month old, use the age-appropriate Bright Futures questions from the Infant Risk Identifier.

** If the infant is two months or older and at least two Bright Futures "not yet" boxes are checked, administer the ASQ-3 within two weeks. If the infant is at least two months old, also use the ASQ: SE-2.

### BF0 GENERAL INFANT DEVELOPMENT – Newborn (Less than 3 weeks)

# Infant Risk Identifier Worksheet

1. Does your baby respond to sound (for example, by blinking, crying, quieting, changing respiration, or showing a startle response)? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby focus on your face and follow it with his/her eyes? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby look at you and respond to your voice? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Does your baby lift his/her head momentarily? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Can your baby move his/her arms, legs and head? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure

## BF1 GENERAL INFANT DEVELOPMENT – Newborn (3 to 4 weeks)

1. Does your baby respond to sound (for example, by blinking, crying, quieting, changing respiration, or showing a startle response)? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby focus on your face and follow it with his/her eyes? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby look at you and respond to your voice? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Is your baby's body generally relaxed? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Can your baby move his/her arms, legs and head? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
6. When lying on his/her tummy, can your baby lift his/her head momentarily? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. When your baby is crying, can he/she be consoled most of the time by being spoken to or held? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Does your baby cry, coo, and smile? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure

## BF2 GENERAL INFANT DEVELOPMENT – 2 Months (1 month 0 days to 2 months 30 days)

1. If you copy the sounds your baby makes, does your baby repeat the sounds back to you? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby seem to pay attention to voices around him/her? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby show an interest in sounds and moving objects? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. When you smile at your baby, does he/she smile back at you? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Does your baby seem to enjoy interacting with you and with other people that take care of him/her? ☐Yes ☐Sometimes * ☐Not yet ☐ Not sure
6. When lying on his/her tummy, can your baby lift his/her head, neck, and upper chest by using his/her forearms for support? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. When your baby is in an upright position, can he/she control his/her head sometimes? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure

## BF4 GENERAL INFANT DEVELOPMENT – 4 Months (3 months 0 days to 4 months 30 days)

1. Does your baby smile and laugh? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby interact with you? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby have different cries for different needs (e.g. hungry, wet, tired)? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Does your baby like to look at and be with you? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Does your baby show you what he/she likes? ☐Yes ☐Sometimes * ☐Not yet ☐Not sure

6. Does your baby babble (e.g. “aaa”, “eee”, “ooo”)?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. Does your baby have good head control?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Does your baby move both sides of his/her body equally?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
9. Does your baby push his/her chest up when on his/her tummy?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
10. Does your baby bat at objects?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
11. Does your baby roll or try to roll from tummy to back?
☐Yes ☐ Sometimes * ☐ Not yet ☐ Not sure

**BF6 GENERAL INFANT DEVELOPMENT – 6 Months (5 months 0 days to 7 months 30 days)**

1. Does your baby smile, laugh, squeal?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby recognize familiar faces?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby enjoy taking turns “talking” with you?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Does your baby string sounds together (babbling “ah”, “oh”, “dada”, “baba”)?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Is your baby beginning to recognize his/her name?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
6. Can your baby sit with support?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. Can your baby roll over?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Can your baby stand and bear weight when held in that position?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

**BF6 GENERAL INFANT DEVELOPMENT – 6 Months (5 months 0 days to 7 months 30 days)**

9. Does your baby mouth objects he/she is interested in?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
10. Does your baby shake, bang, throw and drop objects/ toys?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

**BF9 GENERAL INFANT DEVELOPMENT – 9 Months (8 months 0 days to 10 months 30 days)**

1. Has your baby developed concern about strangers?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby seek you for play and comfort?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby use a wide variety of sounds (babbles, “mama”, “dada”)?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Is your child starting to point out objects?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Does your baby know that an object still exists if it is hidden or out of their sight?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
6. Does your baby play games like “peek-a-boo” and “pat-a-cake”?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. Is your baby crawling?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Does your baby sit without help?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

9. Does your baby move him/herself into a sitting position?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
10. Does your baby move him/herself to a standing position?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
11. Does your baby feed him/herself food with his/her fingers?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

**BF12 GENERAL INFANT DEVELOPMENT – 12 Months (11 months 0 days to 12 months 30 days)**

1. Does your baby play games like “peek-a-boo” and “so big”?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your baby repeat a game or activity that they see you or another child do?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your baby wave “bye-bye”?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Does your baby get upset when you leave him/her?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Does your baby point at a desired object and watch to see if you see it?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
6. Does your baby use one to two words (e.g. “mama”, “dada”)?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. Does your baby jabber as if he/she is talking?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Does your baby follow simple requests (e.g. “give me the ball”)?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
9. Does your baby stand alone?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
10. Does your baby bang two blocks together?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
11. Does your baby eat a variety of foods?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

**BF15 GENERAL INFANT DEVELOPMENT – 15 Months (13 months 0 days to 15 months 30 days)**

1. Does your toddler listen to a story?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
2. Does your toddler pretend to feed a doll a bottle or move cars/trucks around?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
3. Does your toddler show you what he/she wants by pulling, pointing or grunting?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
4. Does your toddler bring you things to show you?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
5. Does your toddler say 2-3 words (other than “mama” or “dada”) and use them correctly?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
6. Does your toddler understand and follow simple commands?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
7. Does your toddler scribble?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
8. Does your toddler walk well, stoop/squat, and then, stand again?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
9. Does your toddler crawl down steps backwards?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
10. Does your toddler stack two blocks?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure
11. Does your toddler feed himself/herself with fingers/spoon and drink from a cup?
☐Yes ☐Sometimes * ☐Not yet ☐Not sure

# Infant Risk Identifier Worksheet

## Finalize/Update Screen

**Beneficiary Name** **Medicaid Id** **Date of Birth** (DDMMYYYY)

Comments

**Completed by**

Screener Name

Professional's Credentials ☐ RN ☐ Social Worker

Entered by Name

Location

- ☐ Home
- ☐ Office
- ☐ Community

☐ I agree that, to the best of my knowledge, the information submitted for this screening is correct.