



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 | | Mother's Social Security Number |

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 for release of the confidential information on this form and any information provided during my 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 This authorization shall remain in effect unless withdrawn in writing.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

All 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 16 Mother's age is less than 18 or unknown
 - Item 32 Mother is over 18 and mother's education is less than 12th grade or unknown
 - Item 30 Mother's race is unknown, other than white, or multiple races selected
 - Item 15 Mother is not married
 - Item 36d The number of prenatal visits is zero, one, or unknown
 - Item 4 Infant's birthweight is less than 2000 grams or less than 4 pounds, 7 ounces
 - Item 40 Mother used tobacco during pregnancy and number of cigarettes per day is more than nine or unknown
 - Item 41 Mother used alcohol during pregnancy or alcohol use is unknown
 - Item 56 Abnormal conditions of the newborn include hyaline membrane disease/RDS, or assisted ventilation required (for 30 minutes or more) or assisted ventilation required (for 6 hours or more)
 - Item 57 Infant has one or more congenital anomalies
- _____
Infant's Healthy Start Screening Score

CHECK ONE
 Referred to Healthy Start based on score.
 Referred to Healthy Start based on factors other than score. Specify: _____
 Not referred to Healthy Start or Patient declined Healthy Start.

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

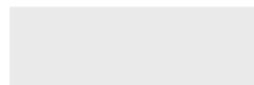
I have explained the Healthy Start program, and if screened, the patient's screening score.

Provider's/Interviewer's Signature and Title

Date (mo/day/yr)

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

0413135, 01/04 mock number 5744-00-3135-5
Distribution of copies: WHITE & YELLOW - With Birth Certificate
PINK - To Baby's File
GREEN - Parent's Copy



Addressograph Imprint