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 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 This authorization shall remain in effect unless withdrawn in writing.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.

DH 3135, 01/12 stock number 5744-100-3135-5
Distribution of copies: WHITE & YELLOW – With Birth Certificate
PINK– To Baby's File
GREEN – Parent's Copy

Addressograph Imprint