



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 This authorization shall remain in effect unless withdrawn in writing.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