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 ______

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 This authorization shall remain in effect unless withdrawn in writing.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