FLORIDA DEPARTMENT OF HEALTH

INFANT RISK SCREEN

Use ink. Be certain to check the appropriate boxes at the top of the birth certificate.

HEALTHY START

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 This authorization shall remain in effect unless withdrawn in writing.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

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	①____	Mother's age is less than 18 or unknown
Item 32	②____	Mother is over 18 **and** mother's education is less than 12th grade or unknown
Item 30	①____	Mother's race is unknown, other than white, or multiple races selected
Item 15	①____	Mother is not married
Item 36d	④____	The number of prenatal visits is zero, one, or unknown
Item 4	④____	Infant's birthweight is less than 2000 grams or less than 4 pounds, 7 ounces
Item 40	①____	Mother used tobacco during pregnancy and number of **cigarettes per day is more than nine** or unknown
Item 41	①____	Mother used alcohol during pregnancy or alcohol use is unknown
Item 54	④____	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 55	④____	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.

DH 3135, 01/04 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