

AMERICAN INDIAN INFANT HEALTH INITIATIVE (AIHI) DATABASE FORM

FSW/CHR complete within first quarter of service and submit with an initial Quarterly Progress Report (DHCS 4496).

	Enrollment date (mm/dd/yy)
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Client/Mother (MOB) Data

MOB ID number	MOB date of birth	Age
American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No	Education—highest grade completed	Still in school <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Gravida (including the current pregnancy)	Para
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	EDC (mm/dd/yy)	Date of first prenatal visit (mm/dd/yy)
		Trimester: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third
Recently gave birth <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	Date of birth	Birth weight child #1
		Birth weight child #2
Type of birth <input type="checkbox"/> Singleton <input type="checkbox"/> Multiple	Gestation <input type="checkbox"/> Preterm (<37 weeks) <input type="checkbox"/> Full term (38-42 weeks) <input type="checkbox"/> Post term (43+ weeks)	

Birth Complications (Check all that apply.)

Mother	Child #1	Child #2
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Medical (including C-section)	<input type="checkbox"/> Medical	<input type="checkbox"/> Medical
<input type="checkbox"/> Drug/alcohol use-related	<input type="checkbox"/> Drug/alcohol exposure	<input type="checkbox"/> Drug/alcohol exposure
<input type="checkbox"/> Infections	<input type="checkbox"/> Developmental	<input type="checkbox"/> Developmental
<input type="checkbox"/> Other (explain): _____	<input type="checkbox"/> Other (explain): _____	<input type="checkbox"/> Other (explain): _____

Living with (check all that apply):

<input type="checkbox"/> Alone	<input type="checkbox"/> Father of baby (FOB)	<input type="checkbox"/> Parent(s)/extended family	<input type="checkbox"/> Friend(s)	Number in household
<input type="checkbox"/> Spouse/Partner (other than FOB)	<input type="checkbox"/> Other (explain): _____			

Source of income (check all that apply):

<input type="checkbox"/> Employment	<input type="checkbox"/> TANF	<input type="checkbox"/> Father of baby (FOB)	<input type="checkbox"/> Other (explain): _____
<input type="checkbox"/> Parent(s)/extended family			

Has child(ren) under age 5 (NOT including the newborn described above):

<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following:	How many?	How old?
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Father (FOB) Data

American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of birth (mm/dd/yy)	Age	If DOB is unknown, enter estimated age	Involved with pregnancy/child <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Assessments (Maternal/Child Risk Profile)

Not done (If checked, submit the results in following quarter.)

Client/MOB Psychosocial Risk Factors (Check all reported and/or observed risks.)

- None identified
- * 1. Substance abuse or positive toxicity: with **OR** without treatment (explain): _____
- * 2. Maternal Hx of mental illness or developmental delay (parent)
- * 3. Maternal Hx of child abuse, rape, molestation, or incest (as a victim)
- * 4. Age <18 years or >40 years
- 5. Single, separated (legal or geographical), divorced
- 6. Self or partner unemployed or seasonal employment
- 7. Education <12th grade or illiterate (English or other language)
- 8. Inadequate income (<200% FPL or on Medi-Cal)
- 9. Unstable housing (homeless, frequent moves, overcrowded, multifamily)
- 10. No telephone or message only
- 11. Lack of transportation/public transport or dependent on others
- 12. First-time mother
- 13. Late (after third trimester), inadequate/sporadic, or no prenatal care
- 14. Hx of therapeutic abortion (actual or contemplated) or multiple miscarriages
- 15. Depression or suicidal ideation (past or present)
- 16. Child(ren) in foster home placement (past or present) or CPS involvement
- 17. Hx of domestic/family violence or rape/sexual assault (as a victim)
- 18. Other (e.g., no support system/person, unplanned pregnancy, unrealistic expectation of child development) (explain): _____

* Each of factors 1-4 is worth 10 points each.
Each of factors 5-18 is worth 1 point.

Refer client to AIHI if she: (1) score s 10 or higher; or (2) scores 5-9 with significant medical risk(s) (see —Medical Risk Factors" on the following page.

Score

Assessments (Maternal/Child Risk Profile) (continued)

Medical Risk Factors *(This section to be completed by PHN.)*

Client/MOB

- No risk factors
- Hx of birth of preterm (<38 weeks), LBW (<2,500g), or SGA infant (explain): _____
- Chronic medical conditions or complications (explain): _____
- Significant communicable disease and/or tuberculosis (explain): _____
- Previous infant mortality (explain): _____
- Other (e.g., gestational diabetes) (explain): _____

Infant (0–1 year)

Infant in home?

- Yes (DOB [mm/dd/yy: _____]) No

If yes, complete the following:

- No risk factors
- Failure to thrive (explain): _____
- Premature (<38 weeks), LBW (<2,500g), or SGA (explain): _____
- Acute or chronic major medical condition (explain): _____
- Known or at risk for developmental delay (explain): _____
- Abused, neglected, or not safe (explain): _____
- Significant communicable disease and/or tuberculosis (explain): _____
- Fetal exposure to drug(s) (explain): _____
- Other (explain): _____

Toddler (1–2 years)

Toddler in home?

- Yes (DOB [mm/dd/yy: _____]) No

If yes, complete the following:

- No risk factors
- Acute or chronic major medical condition (explain): _____
- Abused, neglected, or not safe (current) (explain): _____
- Significant communicable disease and/or tuberculosis (explain): _____
- Other (explain): _____

Preschooler (3–4 years)

Preschooler in home?

- Yes (DOB [mm/dd/yy: _____]) No

If yes, complete the following:

- No risk factors
- Acute or chronic major medical condition (explain): _____
- Abused, neglected, or not safe (current) (explain): _____
- Significant communicable disease and/or tuberculosis (explain): _____
- Other (explain): _____

Completed by

Date last updated