

# Infant Risk Screening Form

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Medicaid No: \_\_\_\_\_ PHRM/ISS Mother? Yes  No

Mothers Name and/or Medicaid Number: \_\_\_\_\_

Positive Risk Screen Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Provider Referred To: \_\_\_\_\_

Provider Telephone: ( ) \_\_\_\_\_

Negative Risk Screen Date: \_\_\_\_\_

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Provider Signature \_\_\_\_\_

Provider Telephone: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Address: \_\_\_\_\_

***Instructions on Reverse Side***

***Risk Factors Affecting or Complicating Infant Care***

<input type="checkbox"/> 759.9 Chromosomal or congenial anomaly Moderate or severe	<input type="checkbox"/> V58.49 Major surgery or Traumatic Injury
<input type="checkbox"/> V293.8 Impairment Hearing/Motor or Orthopedic Vision	<input type="checkbox"/> V46.9 Technology Dependent at Discharge
<input type="checkbox"/> 771.2 Infection-Congenital	<input type="checkbox"/> 984.9 Blood lead level $\geq$ 10mcg/dl
<input type="checkbox"/> V21.33 Very low birth weight $\leq$ 1500 grams	<input type="checkbox"/> V13.7 (PG) Age $\leq$ 16 Primigravida (PG)
<input type="checkbox"/> V21.35 Low birth weight $\leq$ 2500 grams	<input type="checkbox"/> V13.7 (MG) Age $\leq$ 16 Multigravida (MG)
<input type="checkbox"/> V29.8 NICU Grad $\geq$ 7 days	<input type="checkbox"/> V13.7 Late to prenatal care $\leq$ 5 visits(LTC)
<input type="checkbox"/> 783.41 Failure to Thrive (FTT)	<input type="checkbox"/> V60.0 Homeless
<input type="checkbox"/> 783.41 Weight for length or head Circumference $\leq$ 5 <sup>th</sup> percentile or Channels (HC)	
<input type="checkbox"/> 282.60 Sickle Cell Disease	

# Infant Risk Screening Form

## Purpose:

- ❖ This screen is used to identify infants in their first year of life, whose medical status places them at high risk for mortality and/or morbidity.

## Instructions:

- ❖ Demographic information of the infant screened:
  - Enter the name, date of birth, address, Social Security and/or Medicaid number
  - Check yes or no if mother of the infant was enrolled in the PHRM/ISS program.
  - Enter mothers' name and/or Medicaid number.
- ❖ Screen outcome:
  - Enter the positive screen date or negative screen date.
  - Enter the name, telephone number and appointment date of the referring PHRM/ISS case management agency.
  - The provider (physician, physician assistant, nurse practitioner or nurse midwife) who performs the risk screening will sign the form using his/her professional title, telephone number and address.
  - Bill using: T1023-EP Infant Medical Risk Screening and the ICD-9 code of the most significant risk factor used on the screening form.

## Office Mechanics and Filing:

- ❖ Positive Risk Screens:
  - The original is to be filed in the infant's chart and be retained as a permanent part of the record. A positive risk screen copy should be mailed to the referring PHRM/ISS case management agency.
- ❖ Negative Risk Screen:
  - The form is to be kept in the infant's record and filled out when risk factors develop and then processed in the manner described above.

## Retention Period:

- ❖ This form is part of the medical record and must be retained according to agency policy.