



**MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL AND REFERRAL**

Beneficiary Referred For MSS

Yes No



Please mail to: Washtenaw County Public Health, MSS Services, 555 Towner, Ypsilanti, MI 48197 (734)544-6700 , or FAX to (734) 544-6705.

Client Name			Date Of Birth		
G _____	P _____	E.D.C. _____	Last	First	Middle
Address			County		Washtenaw
City _____					
Parent/Guardian/ Spouse/Caregiver			Home Telephone _____		
Additional Contact Person			Other Telephone _____ Telephone No. _____		
Health Care Provider			Telephone No. _____		
Provider Address _____					
Medicaid Health Plan Name			Medicaid No. _____		

Please circle Y if the answer is yes or N if the answer is no.

1. NEED FOR CHILDBIRTH EDUCATION							
1a	Do you know what to expect at different states of your pregnancy?	Y	N	1b	Would you like to learn more about delivery?	Y	N
1c	Do you have experience in caring for a baby?	Y	N	1d	Would you like to learn more about how to take care of your baby?	Y	N
2. NEED FOR TRANSPORTATION TO KEEP MEDICAL APPOINTMENTS							
2a	How do you get around? By car <input type="checkbox"/> Public Transportation <input type="checkbox"/>			2b	How do you plan to get to medical appointments? _____		
3. NEED ASSISTANCE TO CARE FOR YOUR INFANT							
3a	Are you good at following directions/instructions?	Y	N	3b	Barriers Language <input type="checkbox"/> Literacy* <input type="checkbox"/> Education level _____	Y	N
3c	Physical limitations _____			3d	Describe where you live Rent <input type="checkbox"/> Shelter* <input type="checkbox"/> Own your own home <input type="checkbox"/> Motel* <input type="checkbox"/> Car* <input type="checkbox"/> With relatives <input type="checkbox"/>		
4. NUTRITION/HEALTH PROBLEMS							
4a	Describe your eating habits No. of meals eaten per day _____ Skip meals* <input type="checkbox"/> Cook at home <input type="checkbox"/> Fast food <input type="checkbox"/>			4b	Which beverages do you drink often? Pop <input type="checkbox"/> Juice <input type="checkbox"/> Water <input type="checkbox"/> Milk <input type="checkbox"/>		
4c	Do you have any food cravings, e.g. PICA?	Y*	N	4d	Is you blood low in iron (anemia)?	Y*	N
4e	Do you have high blood pressure?	Y*	N	4f	Do you have diabetes now or during other pregnancies?	Y*	N
4g	Have you had problems with weight gain/loss during your pregnancy?	Y*	N	4h	Do you have any other health problems that concern you? Explain _____		

Note An asterisk (*) response indicates an automatic referral for MSS ie. Y*. Non-asterisk items should be referred based on provider judgment.

5. FAMILY SUPPORT					
5a	Are you under 18 years old?	Y*	N		
5b	Who supported you during pregnancy? _____			5c	Who can you count on for support
					-The baby's father? Y N*
					-A parent? Y N*
5d	Who do you currently live with? _____				-A friend? Y N*
					-Anyone else? _____
6. FEELINGS ABOUT CURRENT PREGNANCY					
6a	How many times have you been pregnant?			6b	How many children do you take care of?
6c	What are your feelings about this pregnancy? Happy <input type="checkbox"/> Unhappy* <input type="checkbox"/> Don't know <input type="checkbox"/>			6d	Did your last pregnancy result in fetal (womb) or neonatal (within 30 days of birth) death? NA _____
					Y* N
6e	Have you experienced death of a prior child before age one?				Y* N
7. MOTHER WITH COGNITIVE, EMOTIONAL OR MENTAL NEEDS					
7a	Are you having difficulty coping with taking care of your baby?	Y*	N	7b	Do you feel stressed?
					Y* N
7c	Do you have a history of postpartum depression?	Y*	N	7d	Do you have any concerns about your mental or emotional health?
					Y* N
8. SOCIAL SITUATION					
8a	Do you worry about somebody mistreating you?	Y*	N	8b	Do you worry about anyone mistreating your child/children?
					Y* N
8c	Are you planning on moving during your pregnancy?				Don't know _____ Y N
9. USE OF ALCOHOL, STREET DRUGS OR TOBACCO PRODUCTS					
9a	Did you smoke while you were pregnant?	Y*	N	8b	Do you currently smoke?
					Y* N
9c	Did you drink alcohol (beer, wine, liquor) when you were pregnant?	Y*	N	8d	Do you use drugs not prescribed by your doctor?
					Y* N
9f	Does someone in your household use drugs not prescribed by a doctor?	Y*	N		
10 Other (explain)					

Completed by _____ Date _____

MATERNAL SUPPORT SERVICES RISK SCREENING TOOL

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Childbirth Education. Enrollment in MSS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. An asterisk (*) response indicates an automatic referral for MSS, ie. Y*. Non-asterisk items should be referred based on provider judgment.

CLIENT:

I understand I may qualify to receive MSS, but I do not want these services.

Signature _____ Date _____

MEDICAL or MSS CARE PROVIDER:

Signature _____ Date _____

Print Name _____

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