

MIECHV INFANT BIRTH



Infant ID	<input type="text"/>	Infant Name	<input type="text"/>	◆ Infant DOB*	<input type="text"/>
Client ID	<input type="text"/>	Client Name	<input type="text"/>	DOB	<input type="text"/>
Date	<input type="text"/>	Nurse Home Visitor ID	<input type="text"/>	Nurse Home Visitor Name	<input type="text"/>

Infant First Name: _____ Middle _____ Last _____

***Infant DOB to be entered into the View/Edit Client Demographics screen in ETO.**

Multiple birth

1. Child's Ethnicity (check one):

- Hispanic or Latina/Latino
- Not Hispanic or Latina/Latino

2. Child's Race (check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or other Pacific Islander
- White

3. Gender:

- Male
- Female

4. Birth weight: grams or lbs. oz.

5. ◆ Gestational age at birth: weeks

6. ◆ Was (child's name) admitted to the NICU because of problems?

- Yes, for how many days prior to being discharged? days
- No. If no, did (child's name) have to spend any time in the special care nursery because of problems?
 - Yes, for how many days prior to being discharged? days
 - No

If yes, what was the purpose of the stay (please check all that apply)?

- Low birth weight
- Very low birth weight
- Respiratory distress
- Prematurity
- Congenital defect
- Other (please specify) _____

7. ◆ What was your overall weight gain during pregnancy? lbs.

8. ◆ Has your baby ever received breast milk?

- Yes
- No

MIECHV INFANT BIRTH



M1. If Yes receives breastmilk, is child continuing to get any breast milk?

- Yes
- No *If No, date child stopped getting breast milk? ____/____/____*

9. ♦ Type of labor

- Induced
- Not induced

10. ♦ Type of delivery

- Vaginal
- Caesarean

11. ♦ Did your child receive a newborn screening test in the nursery?

- Yes
- No
- Don't know

12. ♦ Did your child receive a hearing screening in the nursery?

- Yes
- No
- Don't know

Safe Sleep: For questions 13, 14, and 15, select 'N/A' if the infant is in the hospital when the form is completed

13. ♦ How often do you place your infant to sleep on their back?

- Always
- Sometimes
- Never
- N/A

14. ♦ How often do you bed-share with your infant?

- Always
- Sometimes
- Never
- N/A

15. ♦ How often does your infant sleep with soft bedding?

- Always
- Sometimes
- Never
- N/A

MIECHV INFANT BIRTH



16. ♦ During a typical week, how many days do you (and/or a family member) read, tell stories, and/or sing songs to your child?

- 0 1 2 3 4 5 6 7

17. ♦ Does your child have health insurance coverage?

- Yes
 No

If yes, which type of health insurance do you use when you take your child for medical care (please check all that apply)?

- Medicaid
 CHIP
 Tri-Care
 Private
 Other (please specify) _____

M2. Where do you usually take your child for medical care?

- Doctor's/Nurse Practitioner's Office
 Hospital Emergency Room
 Hospital Outpatient
 Federally Qualified Health Center (FQHC)
 Retail Store or Minute Clinic
 Other: _____

M3. Does your child have a usual source of dental care? Yes No