Crystal Home HEALTHCARE
Maternal-Infant Health Program

MR #: _____

INFANT SUPPORT SERVICE CONTINUING PATIENT CARE FORM

Infant's Information:

FULL NAME: _____

Date of birth: ____/____/_____ Sex : ○Male ○Female

Birth weight: _____ Length: _____

Mother's Information:

FULL NAME: _____

Mother's Date of birth: ____/____/_____

Address For Care:

_____
Street Address Apt#

_____
City State Zip

Home #:	Cell #:

Emergency Contact Name:

Relationship Phone

Agency Name and Address **Crystal Home Healthcare MIHP**
15819 Schoolcraft Road Detroit, MI 48227
Phone: (313) 493-4900 Fax: (313) 493-4904

Referral By:

Referral Date: Reported By:

CRYSTAL HOME HEALTH ONLY STAFF ONLY:
Agency 1st Visit Date: Reported By:

Infant Medicaid #: _____ ○Pending

HMO/Health Plan: _____

Mom Medicaid #: _____

Pediatrician/Clinic: _____

Phone# _____

Address _____

CRYSTAL HOME HEALTHCARE STAFF USE ONLY: COMMENTS/INSTRUCTIONS FOR CARE

Plan of Care

Assess and Evaluate: ○Growth and Development ○Neurological Status ○Hydration/Nutrition

Assess/Evaluate Functioning: ○Bonding ○Growth and Development Stimulation
○ Safety ○Comfort Measures/Cry Response

Knowledge Deficit/Health Promotion:
○Signs & Symptoms of Illness in Infant ○ Alternate Caregiver ○Umbilical Cord/Circ Care
○Infant Care Bathing & Dressing ○Medical Appointments ○ Infant Feeding/Formula Prep
○Immunizations ○Infant Activity/Rest Cycle

HISTORY (Risk Criteria)
○Abuse of alcohol or drugs, especially use of cocaine
○Mother under the age of 18 **and** has no family support
○Family history of child abuse/neglect
○Failure to thrive
○Low birth weight (less that 2500 grams) 5lbs, 5oz.
○Mother has cognitive, emotional or mental impairment (low function)
○Homeless or dangerous living/home situation
○Condition that may place infant at risk (death, significant impairment, illness, etc.):
_____

Client Needs/ determine referrals needed for:
○ WIC
○ Breastfeeding
○ Parenting Classes
○ Food
○ Transportation
○ Pediatrician Ref
○ Baby Items

************This form can be faxed back to 313.493.4904************

CRYSTAL HOME HEALTHCARE FIELD STAFF USE ONLY

TIME & DATE OF VISIT ATTEMPTS	Attempt 1 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	Attempt 2 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	Attempt 3 Time_____am pm Date ____/____/_____ ○Drive By ○Call ○Letter	**RETURNED TO OFFICE DATE**
PLAN OF CARE VISITS	SW Anticipated Visits	RN Anticipated Visits	RD Anticipated Visits	**Case Mgr Initials**