## **Simple Rapid Assessment[[1]](#footnote-1)**

**Instructions:** Administer this rapid assessment whenever a caregiver with a child under 2 years is encountered and a referral is indicated. Do not ask the last 5 questions in italics under **LOOK** but note them down if observed.

If any difficulties are observed, refer the caregiver-baby pair for a Full Assessment or other support as appropriate. If anything in **RED** is circled, then deliver a full assessment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cut Here** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMPLETE IF FULL ASSESSMENT IS INDICATED**

Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When to attend: Immediately / date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR REFERRAL:

A) Full IYCF Assessment needed

B) Medical care needed: (reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Simple Rapid Assessment Referral Form** |
| Name of baby: | Date of Birth/Age: | Girl | Boy |
| Age of baby | 0-59 months0-28 days | 6-12 months | 12-24 months |
| **ASK** |
| Is the baby being breastfed? |  Yes No |  Yes No |  Yes No |
| Is the baby getting anything else to eat/drink? |  Yes No |  Yes No |  Yes No |
| Is the baby unable to suckle at the breast? |  Yes No |  Yes No |  Yes No |
| Are there any other difficulties in breastfeeding? |  Yes No |  Yes No |  Yes No |
| Does the mother or caregiver feel there are feeding concerns? |   Yes No |  Yes No |  Yes No |
| Did the caregiver request infant formula? |  Yes No |  Yes No |  Yes No |
| **LOOK** |
| *Does the baby look very thin, lethargic or ill?* |  Yes No |  Yes No |  Yes No |
| *Is the mother or child visibly diabled?* |  Yes No |  Yes No |  Yes No |
| *Does the mother look visibly young?* |  Yes No |  Yes No |  Yes No |
| *Is the caregiver the child’s mother?* |  Yes No |  Yes No |  Yes No |

1. Adapted from Module 2 on IFE, Core Manual, Section 3, IFE Core Group, 2007 [↑](#footnote-ref-1)