



MAMI ASSESSMENT FORM (Scenario A)

Basic Information

Infant name (first & last name)	Liya Gebre				ID no	23456
					Date of assessment	__31__ / __07__ / __2023__
Sex	<input checked="" type="checkbox"/> male	<input type="checkbox"/> female	Infant age:	__ months 6 weeks	Date of birth	__20__ / __06__ / __2023__
Primary caregiver name	Amina Gebre				Relationship to infant	<input checked="" type="checkbox"/> mother
					<input type="checkbox"/> grandmother	other:
Source of referral	<input type="checkbox"/> community screening	<input type="checkbox"/> outpatient clinic	<input type="checkbox"/> inpatient care	<input type="checkbox"/> self-referral	other: Vaccination clinic	

STEP 1 CHECK FOR DANGER SIGNS (infant)

DANGER SIGNS	Unable to breastfeed / drink?		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
	Vomits everything?		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
	Bilateral pitting oedema (+, ++ or +++)?		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
	Mother appears out of touch with reality or at risk of harming herself or infant; visible physical neglect (mother or infant)		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
	Other IMCI danger sign(s)? Specify:			
ACT	IF ANY DANGER SIGN → refer URGENTLY to hospital			

STEP 2 ASSESS CLINICAL SIGNS AND SYMPTOMS (infant)

CLINICAL SIGNS & SYMPTOMS	Classify according to IMCI	green	Yellow	Pink	CLINICAL SIGNS & SYMPTOMS	Classify according to IMCI	green	Yellow	Pink
	Diarrhoea	<input checked="" type="checkbox"/> none	<input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe		Any other illness (refer to IMCI)	<input checked="" type="checkbox"/> none	<input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe
	Fever	<input checked="" type="checkbox"/> none	<input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe		Specify other illness:			
	Cough	<input checked="" type="checkbox"/> none	<input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe		Congenital condition/disability causing feeding difficulty (e.g. cleft lip, tongue tie)	<input type="checkbox"/> none	yes: Cleft lip	
	Severe pallor (anaemia)	<input checked="" type="checkbox"/> none	-	<input type="checkbox"/> severe					

STEP 3 ASSESS GROWTH (infant)

MUAC:	108 mm	Weight:	3.4 kg	Birthweight:	2.3 kg
Length:	51.0 cm	WAZ:	< -2	WLZ:	> -2
Classify weight-for-age z-score (WAZ) or weight-for-length z-score (WLZ) using infant growth charts.					
WAZ < -2.0		<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes		
WLZ < -2.0		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes		
MUAC less than 110mm (infants < 6 weeks)		<input type="checkbox"/> no	<input type="checkbox"/> yes (age < 6 weeks)		
MUAC less than 115mm (infants 6 weeks to < 6 months)		<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes (age 6 weeks – 6 months)		
Recent weight loss or failure to gain adequate weight		<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes		
Other - specify:					

STEP 4 ASSESS KEY MAMI RISK FACTORS (infant & mother)

Mother absent or dead	<input checked="" type="checkbox"/> no	<input type="checkbox"/> Absent or dead	Mother's MUAC less than 230mm	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
Low birthweight (2500g or less)	<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes	Infant cries excessively / has sleep problems (reported)	<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes
Born preterm	<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes	Any other concerns (e.g., maternal TB, other illness, colic)?	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes
Multiple birth	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes	Specify other concern:		
Adolescent mother (under 19 years)	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes			
Mother HIV+ with concerns	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes			
Mother's MUAC	__240__ mm				

STEP 5 SCREEN FOR FEEDING RISK (infant & mother)			
		LOW FEEDING RISK	POTENTIAL FEEDING RISK
Are you the infant's biological mother? If not, ask: What is the reason?	<input checked="" type="checkbox"/> biological mother	<input type="checkbox"/> mother dead or absent	
Is the infant breastfed?	<input checked="" type="checkbox"/> breastfed	<input type="checkbox"/> not breastfed	
If infant is breastfed: What other foods or drinks does the infant receive?	<input checked="" type="checkbox"/> none (only breastmilk)	<input type="checkbox"/> any other foods or drinks	
Any problems feeding your infant?	<input type="checkbox"/> no	<input checked="" type="checkbox"/> yes	
ACT ANY SIGN OF POTENTIAL FEEDING RISK → conduct feeding assessment			
Infant feeding practices:	<input checked="" type="checkbox"/> exclusively breastfed	<input type="checkbox"/> mixed feeding	<input type="checkbox"/> not breastfed
Feeding risk based on assessment:	<input type="checkbox"/> low feeding risk		<input checked="" type="checkbox"/> moderate feeding risk
Details of any feeding difficulties:	<i>Mother concerned about gap in his lip, poor attachment, short duration</i>		

STEP 6 SCREEN FOR MATERNAL MENTAL HEALTH CONCERN				
Over the last two weeks, how often have you been bothered by the following problems?	not at all	several days	more than half the days	nearly every day
Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Add column scores:		2		
SCREENING SCORE:	2			
Screening score 2 or less, but health worker concerned about mother's mental health	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes, specify:		
ACT	SCREENING SCORE 3+ OR CONCERN ABOUT MOTHER'S MENTAL HEALTH → Conduct mental health assessment			ASSESSMENT SCORE:

MAMI ASSESSMENT SUMMARY			
Step 1: Any clinical sign requiring referral to hospital or specialised services?	<input type="checkbox"/> no	-	<input type="checkbox"/> yes
Step 2: Any sign of infant growth failure?	<input type="checkbox"/> no	<input type="checkbox"/> yes	-
Step 3: Any other risk factors?	<input type="checkbox"/> no	<input type="checkbox"/> yes	-
Step 4: Any sign of moderate feeding risk?	<input type="checkbox"/> no	<input type="checkbox"/> yes	-
Step 5: Maternal mental health assessment score (if applicable) Classify & refer	<input type="checkbox"/> 0 – 9 and 'no' to Question 9 (thoughts of self-harm)	<input type="checkbox"/> 10 – 14 and 'no' to Question 9 (thoughts of self-harm)	<input type="checkbox"/> 15+ and/or 'yes' to Question 9 (thoughts of self-harm)
Classify & refer	LOW RISK: If all signs circled, refer to routine healthcare & IYCF counselling	MODERATE RISK: If any sign circled, enrol in MAMI Outpatient Care	HIGH RISK: If any sign circled, refer to hospital or specialised services
Other – specify:			
Main problems identified:	1.		
	2.		
	3.		
If not following advice above on referral options, document why:			