



# MAMI ASSESSMENT FORM

## Basic Information

Infant name (first & last name) <i>Mohammed Arafat</i>		ID no <i>23456</i>
		Date of assessment <i>31 / 07 / 2021</i>
Sex <input checked="" type="checkbox"/> male <input type="checkbox"/> female	Infant age: <i>4</i> months <i></i> weeks	Date of birth <i>30 / 03 / 2021</i>
Primary caregiver name <i>Khatera Mohammed</i>		Relationship to infant <input checked="" type="checkbox"/> mother <input type="checkbox"/> grandmother other: <i></i>
Source of referral <input type="checkbox"/> community screening <input checked="" type="checkbox"/> outpatient clinic <input type="checkbox"/> inpatient care <input type="checkbox"/> self-referral	other: <i></i>	

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

## STEP 3 ASSESS GROWTH (infant)

MUAC:	<i>115</i> mm	Weight:	<i>4.6</i> kg	Birthweight:	<i>unknown</i>
Length:	<i>58.5</i> cm	WAZ:	<i>&lt;-2</i>	WLZ:	<i>&lt;-2</i>
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 type="checkbox"/> no <input checked="" 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 checked="" type="checkbox"/> no <input type="checkbox"/> yes (age 6 weeks – 6 months)			
Recent weight loss or failure to gain adequate weight		<input type="checkbox"/> no <input checked="" type="checkbox"/> yes			
Other - specify: <i></i>					

## 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 checked="" type="checkbox"/> no <input type="checkbox"/> yes	Infant cries excessively / has sleep problems (reported)	<input checked="" type="checkbox"/> no <input type="checkbox"/> yes
Born preterm	<input checked="" type="checkbox"/> no <input type="checkbox"/> yes	Any other concerns (e.g., maternal TB, other illness, colic)?	<input type="checkbox"/> no <input checked="" type="checkbox"/> yes
Multiple birth	<input checked="" type="checkbox"/> no <input type="checkbox"/> yes	Specify other concern: <i>Baby has attended outpatients 4 times illness since birth. Mother anxious about him as he looks very thin and is often unwell.</i>	
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	<i>250</i> mm		

STEP 5 SCREEN FOR FEEDING RISK (infant & mother)		
	<b>LOW FEEDING RISK</b>	<b>POTENTIAL FEEDING RISK</b>
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
<b>ACT ANY SIGN OF POTENTIAL FEEDING RISK → conduct feeding assessment</b>		
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 mentions each breastfeed is short duration, She often interrupts breastfeed to do other household chores.</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 type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3
Add column scores:			4	
SCREENING SCORE:	4			
Screening score 2 or less, but health worker concerned about mother's mental health	<input type="checkbox"/> no	<input type="checkbox"/> yes, specify:		
<b>ACT</b>	<b>SCREENING SCORE 3+ OR CONCERN ABOUT MOTHER'S MENTAL HEALTH → Conduct mental health assessment</b>			<b>ASSESSMENT SCORE: 12</b>

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)
<b>Classify &amp; refer</b>	<b>LOW RISK:</b> If all signs circled, refer to routine healthcare & IYCF counselling	<b>MODERATE RISK:</b> If any sign circled, enrol in MAMI Outpatient Care	<b>HIGH RISK:</b> 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:			