



MAMI ASSESSMENT FORM

Basic Information

Infant name (first & last name) <i>Rose Okello</i>		ID no <i>98765</i>
		Date of assessment <i>31-Jul - 2021</i>
Sex <input type="checkbox"/> male <input checked="" type="checkbox"/> female	Infant age: <i>2</i> months <i>0</i> weeks	Date of birth <i>30 - Mar - 2021</i>
Primary caregiver name <i>Florence Okello</i>		Relationship to infant <input checked="" type="checkbox"/> mother <input type="checkbox"/> grandmother other:
Source of referral <input checked="" type="checkbox"/> community screening <input type="checkbox"/> outpatient clinic <input type="checkbox"/> inpatient care <input type="checkbox"/> self-referral	other:	

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 type="checkbox"/> none	<input checked="" type="checkbox"/> mild/moderate	<input type="checkbox"/> severe	Congenital condition/disability causing feeding difficulty (e.g. cleft lip, tongue tie)	<input checked="" type="checkbox"/> none	yes:			
Severe pallor (anaemia)	<input checked="" type="checkbox"/> none	–	<input type="checkbox"/> severe						

STEP 3 ASSESS GROWTH (infant)

MUAC:	<i>113</i> mm	Weight:	<i>3.3</i> kg	Birthweight:	<i>2.1</i>
Length:	<i>52</i> cm	WAZ:	<i><-2</i>	WLZ:	<i>>-2.0</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 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 type="checkbox"/> no	<input checked="" 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 type="checkbox"/> no	<input checked="" 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 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 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 type="checkbox"/> no	<input checked="" type="checkbox"/> yes			
Mother HIV+ with concerns	<input checked="" type="checkbox"/> no	<input type="checkbox"/> yes			
Mother's MUAC	<i>225</i> 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 type="checkbox"/> none (only breastmilk)	<input checked="" 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 type="checkbox"/> exclusively breastfed	<input checked="" type="checkbox"/> mixed feeding <input type="checkbox"/> not breastfed
Feeding risk based on assessment:	<input type="checkbox"/> low feeding risk	<input type="checkbox"/> moderate feeding risk
Details of any feeding difficulties:	<i>Mother mentions she isn't sure she has enough milk as the baby is small. Her mother-in-law is suggesting she introduces foods, she's currently giving some sugar water as well as breastmilk.</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:		
ACT	SCREENING SCORE 3+ OR CONCERN ABOUT MOTHER'S MENTAL HEALTH → Conduct mental health assessment			ASSESSMENT SCORE: 11

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:			