



MAMI ASSESSMENT FORM

Basic Information

Infant name (first & last name)		ID no	
		Date of assessment ____/____/____	
Sex	<input type="checkbox"/> male <input type="checkbox"/> female	Infant age:	____ months ____ weeks
		Date of birth ____/____/____	
Primary caregiver name			Relationship to infant <input 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: _____	

STEP 1 CHECK FOR DANGER SIGNS (infant)

DANGER SIGNS	Unable to breastfeed / drink?		<input type="checkbox"/> no <input type="checkbox"/> yes
	Vomits everything?		<input type="checkbox"/> no <input type="checkbox"/> yes
	Bilateral pitting oedema (+, ++ or +++)?		<input 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 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 type="checkbox"/> mild/moderate	<input type="checkbox"/> severe	
	Fever	<input type="checkbox"/> none <input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe	
	Cough	<input type="checkbox"/> none <input type="checkbox"/> mild/moderate	<input type="checkbox"/> severe	
	Severe pallor (anaemia)	<input type="checkbox"/> none	–	<input type="checkbox"/> severe
CLINICAL SIGNS & SYMPTOMS	Classify according to IMCI	green	Yellow	Pink
	Any other illness (refer to IMCI)	<input 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 type="checkbox"/> none	yes:	

STEP 3 ASSESS GROWTH (infant)

MUAC:	_____ mm	Weight:	_____ kg	Birthweight:	_____ kg
Length:	_____ cm	WAZ:		WLZ:	
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 type="checkbox"/> yes			
WLZ < -2.0 (> -3.0)		<input 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 type="checkbox"/> yes (age 6 weeks – 6 months)			
Recent weight loss or failure to gain adequate weight		<input type="checkbox"/> no <input type="checkbox"/> yes			
Other - specify: _____					

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

Mother absent or dead	<input type="checkbox"/> no <input type="checkbox"/> Absent or dead	Mother's MUAC less than 230mm	<input type="checkbox"/> no <input type="checkbox"/> yes
Low birthweight (2500g or less)	<input type="checkbox"/> no <input type="checkbox"/> yes	Infant cries excessively / has sleep problems (reported)	<input type="checkbox"/> no <input type="checkbox"/> yes
Born preterm	<input type="checkbox"/> no <input type="checkbox"/> yes	Any other concerns (e.g., maternal TB, other illness, colic)?	<input type="checkbox"/> no <input type="checkbox"/> yes
Multiple birth	<input type="checkbox"/> no <input type="checkbox"/> yes	Specify other concern:	
Adolescent mother (under 19 years)	<input type="checkbox"/> no <input type="checkbox"/> yes		
Mother HIV+ with concerns	<input type="checkbox"/> no <input type="checkbox"/> yes		
Mother's MUAC	_____ 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 type="checkbox"/> biological mother	<input type="checkbox"/> mother dead or absent
Is the infant breastfed?	<input 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 type="checkbox"/> any other foods or drinks
Any problems feeding your infant?	<input type="checkbox"/> no	<input type="checkbox"/> yes
ACT ANY SIGN OF POTENTIAL FEEDING RISK → conduct feeding assessment		
Infant feeding practices:	<input 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 type="checkbox"/> moderate feeding risk
Details of any feeding difficulties:		

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 type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Add column scores:				
SCREENING SCORE:				
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:	

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:			