MATERNAL INFANT HEALTH PROGRAM
PROFESSIONAL VISIT PROGRESS NOTE

Beneficiary ID #: ____________________

Beneficiary Information

Name: ____________________

Parent/ Guardian: ____________________

Type of Visit: ☐ Maternal ☐ Infant

Location of Visit: ☐ Home ☐ Office ☐ Other

Date of Visit: ____________________

Insurance Information

Medicaid Number: ____________________

Any Changes in Medicaid? ☐ YES ☐ NO

Managed Care: ☐ YES ☐ NO

If yes, Name and ID#: ____________________

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Purpose of visit (per care plan)

#1 Problem/Needs Addressed:

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____

Interventions Provided:

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#2 Problem/Needs Addressed

____

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Interventions Provided

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Beneficiary's Name: ______________________

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PROFESSIONAL VISIT PROGRESS NOTE

Follow-Up Plan Next Steps

Family Planning Issues:

Immunization Issues:

CBE/PE Issues:

Last Medical Care Provider Visit: __________

Next Medical Care Provider Visit: __________

Date of Next Visit by MIHP Provider: __________

Referrals Needed:
Referrals Made:
Care Plan Update Needed ☐ Yes ☐ No

Signature Date