



# Children 1st

## Screening and Referral Form

**DIRECTIONS:** Please complete form on every child, birth to age 5, having any of the conditions listed on 1st or 2nd page. Check or fill in as much information as possible. Send form to local Children 1st Coordinator.

Referral Source: \_\_\_\_\_ Date Received: \_\_\_\_\_

SECTION A		CHILD AND FAMILY INFORMATION	
CHILD'S INFORMATION		MOTHER'S INFORMATION	
Child: _____ Last Name                      First                      MI Date of Birth: _____ Birth weight: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Gestational Age: _____ Select race: (Mark all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown <input type="checkbox"/> Hawaiian/ Other Pacific Islander Latino/Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospital: _____ Discharge Date: _____ Transfer Hospital: _____ Discharge Date: _____ Type of Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> PeachCare <input type="checkbox"/> CareSource <input type="checkbox"/> WellCare CMO <input type="checkbox"/> PeachState CMO <input type="checkbox"/> Private <input type="checkbox"/> Amerigroup CMO <input type="checkbox"/> Tri-Care <input type="checkbox"/> Unknown <input type="checkbox"/> None Child's Insurance #: (if known) _____		Mother: _____ Last Name                      First                      MI                      Maiden Age: _____ Date of Birth: _____ Education: (last grade completed) Marital Status: <input type="checkbox"/> M <input type="checkbox"/> NM <input type="checkbox"/> SEP <input type="checkbox"/> D <input type="checkbox"/> W Live in Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No Prenatal Care: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> None Parity G: _____ P: _____ Pre-Term: _____ AB: Elective/Spontaneous _____ / _____ Parent's Medicaid #: _____	
		FATHER'S INFORMATION	
		Last Name                      First                      MI	
		GUARDIAN/FOSTER CARE REFERRALS	
		Guardian/Foster Parent Last Name    First                      Phone Number	
		DFCS Case Worker Last Name    First                      Phone Number                      Fax Number	
LANGUAGE NEEDS			
Primary Language: _____ Translator/Interpreter Needed: <input type="checkbox"/> Y <input type="checkbox"/> N			
CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER		CONTACT INFORMATION	
Name _____ Street or Route _____ City _____ State _____ Zip _____ Phone _____ Fax _____		Child Lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent Child's Address: _____ Street /Route Apt Complex # / Mobile Hm Park# City                      County                      Zip Phone #: _____ Emergency Contact #: _____ Caregiver email address: _____	
SECTION B                      HOSPITAL INFORMATION			
Newborn Hearing Screening: <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening Inpatient: Date: ____/____/____ Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> AOE <input type="checkbox"/> AABR <input type="checkbox"/> Other Outpatient: Date: ____/____/____ Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> AOE <input type="checkbox"/> AABR <input type="checkbox"/> Other Newborn Bloodspot Metabolic Screening: <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening		<b>Equipment:</b> <input type="checkbox"/> _____	<b>Vaccines Given During Hospital Stay:</b> Hepatitis B Vaccine: (date) _____ HBIG: (date) _____
SECTION C                      LEVEL 2 RISK CONDITIONS (3 OR MORE MUST BE PRESENT FOR ELIGIBILITY)			
<b>Conditions Identified at Birth</b>		<b>Child Abuse Prevention Treatment Act (CAPTA)</b> <b>All CAPTA referrals are automatic referral (Child age birth to 3 years)</b> Z62.21 - Z62.29 <input type="checkbox"/> Foster Care Y07.11 - Y07.0, T74.12XA - T <input type="checkbox"/> Child Maltreatment Syndrome (Substantiated Case)	
P01.0 - P04.9 <input type="checkbox"/> Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy) P08.00 - P07.18 <input type="checkbox"/> Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams O09.30 - O09.33 <input type="checkbox"/> Insufficient Prenatal Care (Little or no prenatal care) O09.611 - O09.629 <input type="checkbox"/> Young Prima-/Multi-gravida (Maternal Age <18 years) O09.70 O09.73 <input type="checkbox"/> Education Circumstances (Maternal Education <12 Years)		<b>DFCS Referrals (no CAPTA)</b> Z62.21 - Z62.29, Y07.9 - Y07.11 <input type="checkbox"/> Foster Care (over age 3) T74.12A - T74.32XS <input type="checkbox"/> Child Maltreatment Substantiated Case (over age 3) T76.12XA - T76.32XS <input type="checkbox"/> Unsubstantiated or sibling of victim of substantiated case (birth to 5) F80.X - F89, Z00.70 - Z00.71 <input type="checkbox"/> Child under age 5 exhibiting physical or developmental delay	
Socio-Environmental Conditions Present in the Family			
Z81.8 <input type="checkbox"/> Psychiatric condition (Parental Mental Illness, Depression) Z59.0 <input type="checkbox"/> Lack of Housing (Homelessness) Z63.32 <input type="checkbox"/> Family disruption due to child in welfare custody Z64.1 <input type="checkbox"/> Multiparity - in Mother (<20 Years of age, >3 pregnancies) Z65.3 <input type="checkbox"/> Legal Circumstances (Parental Incarceration) Z80.0 - Z84.89 <input type="checkbox"/> Family History of (Specify) _____ (Illness/disability affecting care of child) T14.90 / T14.8 <input type="checkbox"/> Child Injuries (>3 in 1 Year) Requiring Medical Attention Specify: _____		Z81.0 <input type="checkbox"/> Mental Retardation (Parental Mental Retardation) Z59.5 <input type="checkbox"/> Inadequate Material Resources (Affecting Care of Child) Z62.898/F94.2 <input type="checkbox"/> Parent-Child Problems (Questionable Mother/Child Attach) Z56.0 <input type="checkbox"/> Parental Unemployment Z63.79 <input type="checkbox"/> Other Psych. or Physical Stress, (History of Family Violence)	
SECTION D                      SIGNATURES			
Name of Person Completing Form _____ Agency _____		Email Address _____ Phone _____ Date _____	
Parent Signature (Encouraged but not required for referral) _____		Parent Informed of Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

**SECTION E (check all that apply) LEVEL 1 RISK CONDITIONS**  
 (Medical/Biological Conditions Present in Child Indicating Referral to Public or Private Sector Care)

Infectious and Parasitic Diseases	Conditions Originating in the Perinatal Period
B20 <input type="checkbox"/> HIV A50.9 <input type="checkbox"/> Syphilis	P04.3 or Q86.0 <input type="checkbox"/> Fetal Alcohol Syndrome P05.00 - P05.10 <input type="checkbox"/> Light-for-dates infant without fetal malnutrition unspecified (birth weight < 10% for gestational age)
Mental Disorders	P05.X <input type="checkbox"/> Fetal Growth Retardation (Intrauterine Growth Reduction-IUGR) P07.00 - P07.03 <input type="checkbox"/> Disorders r/t extreme immaturity of infant (BW < 999 gms) P07.10-P07.16 <input type="checkbox"/> Disorders r/t other preterm infants (BW 1000-1500 gms) P10.0 <input type="checkbox"/> Subdural and cerebral hemorrhage due to birth trauma P84 <input type="checkbox"/> Severe birth asphyxia (APGAR < 3 at 5 Minutes) P27.0-P27.8 <input type="checkbox"/> Chronic Respiratory Disease in perinatal period (Broncho-pulmonary Dysplasia)
Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders	P28.3 <input type="checkbox"/> Primary apnea or other apnea in newborn P28.9 <input type="checkbox"/> Unspec. Respir. Condition of fetus/newborn (vent > 48hrs) P35.0 <input type="checkbox"/> Congenital Rubella P35.1 <input type="checkbox"/> Congenital cytomegalovirus infection (CMV) P35.2 or P37.X <input type="checkbox"/> Other congenital infection in perinatal period (Herpes Simplex-congenital, Toxoplasmosis)
Diseases of the Blood and Blood-Forming Organs	P52.21-P52.22 <input type="checkbox"/> Intraventricular Hemorrhage (IVH), Grade III or IV P52.3 or P59.X <input type="checkbox"/> Perinatal jaundice d/t hepatocellular damage (NB Hepatitis) P59.9 <input type="checkbox"/> Neonatal jaundice (requiring exchange transfusion) P77.3 <input type="checkbox"/> Stage III necrotizing enterocolitis in newborn P90 <input type="checkbox"/> Convulsions in newborn P92.8-P92.9 <input type="checkbox"/> Feeding Problems in newborn (severe reflux/feeding tube) P96.1-P96.2 <input type="checkbox"/> Drug Withdrawal Syndrome in Newborn P91.2 <input type="checkbox"/> Periventricular/Preventricular Leukomalacia (PVL) C1COP.1 <input type="checkbox"/> NICU Stay > 5 days
Diseases of the Nervous System and Sense Organs	Symptoms, Signs and Ill-Defined Conditions
G00.9 <input type="checkbox"/> Meningitis, Bacterial G03.9 <input type="checkbox"/> Meningitis, All Other G04.90 <input type="checkbox"/> Encephalitis G80.9 <input type="checkbox"/> Infantile cerebral palsy G40.901 - GG93.919 <input type="checkbox"/> Epilepsy/Seizure Disorder G93.41 - G93.49 or 167.83 <input type="checkbox"/> Encephalopathy G60.0 - G60.9 or G61.0 or G71.2 <input type="checkbox"/> Neuromuscular Disorder H35.159 or H35.169 <input type="checkbox"/> Retinopathy of Prematurity (Grades 4 or 5) H54.0 or H35.169 <input type="checkbox"/> Blindness and low vision <b>Specify (code, diagnosis):</b> _____ H66.X <input type="checkbox"/> Unspecified otitis media – chronic (recurrent or persistent) H90.X - H91 <input type="checkbox"/> Hearing Loss <b>Specify (code, diagnosis):</b> _____ C1DNS.1 <input type="checkbox"/> Suspected Hearing Impairment	P92.6 <input type="checkbox"/> Failure to Thrive/Growth Deficiency (growth below 5th %) R68.89 <input type="checkbox"/> Other abnormal clinical findings <b>Specify (code, diagnosis):</b> _____
Serious Problems or Abnormalities of Body Systems	Injury and Poisoning
100 - 195 <input type="checkbox"/> Heart/Circulatory System J00 - J86.9 <input type="checkbox"/> Respiratory System J45.20 - J45.22 <input type="checkbox"/> Asthma K00 - K90.9 <input type="checkbox"/> Digestive System N00.0 - N94.9 <input type="checkbox"/> Genito-Urinary System M32.10 - M36.8 <input type="checkbox"/> Musculoskeletal System and Connective Tissue Q00.0 - Q99.9 <input type="checkbox"/> Congenital anomalies Q00.0 <input type="checkbox"/> Anencephaly Q05.0 - Q05.9 or Q04.5 <input type="checkbox"/> Spina Bifida/Myelomeningocele Q02 <input type="checkbox"/> Microcephaly Q03.8 or Q3.9 <input type="checkbox"/> Hydrocephaly Q35.9 <input type="checkbox"/> Cleft Palate/Lip <b>Specify Conditions for All Above (include Diagnosis Code):</b> _____ _____	S09.8XXA or S09.90XA <input type="checkbox"/> Other and unspecified injury to head T56.0XXX <input type="checkbox"/> Toxic effect of lead and its compounds, including fumes Lead Level > 20 µg/dl (Venous) <b>Specify:</b> _____ Lead Level > 10 <20 µg/dl (Venous) <b>Specify:</b> _____ C1INJ.1 <input type="checkbox"/> Ototoxic medications including chemotherapy
	Other Significant Conditions
	Z20.5 - Z22.52 <input type="checkbox"/> Carrier/suspected carrier of viral hepatitis (Hep. B in Mom) Z82.2 <input type="checkbox"/> Family history of deafness or hearing loss Z63.72 <input type="checkbox"/> Alcoholism or Substance Abuse in Family (Maternal use of street, prescription or OTC drugs via self-report, drug screen or court record) Q85.0X <input type="checkbox"/> Neurofibromatosis

**SECTION F REFERRAL CRITERIA LEGEND**

Health Department Staff: Please see eligibility lists for Babies Can't Wait (BCW), Children's Medical Services (CMS), 1st Care, Early Hearing Detection and Intervention (EHDI), Home Visiting, Genetics, and Lead Programs in order to appropriately refer children.

**SECTION G COMMENTS**

Has child received a recent developmental screening?:  Not screened  Yes, screened by \_\_\_\_\_ (Please attach results)  
 Measure used: \_\_\_\_\_ Date screening completed \_\_\_\_\_ Scores \_\_\_\_\_