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

Screening and Referral Form

SECTION A — CHILD AND FAMILY INFORMATION

Child: Last Name First MI

Mother: Last Name First MI Maiden

Father: Last Name First MI

CHILD'S INFORMATION

Child's Address _____
Street/Route Apt Complex # / Mobile Hm Park #

_____
City County Zip

Phone # _____ **Emergency Contact #** _____

Directions to Home _____

_____

Latino/Hispanic: Y/N
Select one or more race: (1) White (2) Black or African American (3) American Indian or Alaska Native (4) Asian (5) Native Hawaiian or Other Pacific Islander

Sex: Male Female Unknown Date of Birth _____
Birth weight_____ **Gestational Age**_____

Hospital _____ **Discharge Date** _____
Transfer Hospital _____ **Discharge Date** _____

Type of Insurance: Private Tri-Care PeachCare Medicaid None/Unknown
Medicaid # (if known)_____

LANGUAGE NEEDS

Primary Language:_____Translator/Interpreter Needed: Y/N

MOTHER'S INFORMATION

Age_____ **Date of Birth**_____

Education (last grade completed) _____

Marital Status *(circle only 1)*: M NM SEP D W
Live in Partner: Y/N

Parity G:____ P:____ Pre-Term:____ AB: Elective/Spontaneous ___/___

Prenatal Care 1st 2nd 3rd None

Medicaid #_____

GUARDIAN/FOSTER PARENT (If different from above)

_____
Last Name First MI

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

_____
Name

_____
Street or Route

_____
City State Zip

_____ _____
Phone **Fax**

SECTION B — HOSPITAL INFORMATION

Newborn Hearing Screening: **Not screened** **Family Refused Screening**
Inpatient: Date: ___/___/___ L: Passed/Referred R:Passed/Referred **Equipment**: AOAE AABR Other
Outpatient: Date: ___/___/___ L: Passed/Referred R:Passed/Referred **Equipment**: AOAE AABR Other

Vaccines Given During Hospital Stay:
Hepatitis B Vaccine (date) _____
HBIG (date) _____

SECTION C — LEVEL 1 RISK CONDITIONS (Families Offered In-Home Assessment)

(Circle all that apply)

Conditions Identified at Birth

XXX.11	***Negative Family Index (includes XXX.12, V62.3 & V62.9)***
XXX.12	Maternal Age <20 years
V62.3	Maternal Education <12 Years
V62.9	No Father's Name on Birth Certificate
XXX.13	***Negative Healthy Start Index (765, V23.7, & XXX.17)***
765	Birth weight <2500 Grams (5 lbs. 8 oz.)
V23.7	No 1st Trimester Prenatal Care
XXX.17	Mother Smoked and/or Drank (> 7 drinks/week) during Pregnancy
XXX.14	***2 or More of the 6 Risk Conditions Listed Above***

Medical/Biological Conditions Present in the Child (Any 1)

●	XXX.15	Special Care Nursery >48 hours (specify medical conditions on back)
●	764.9	Small for Gestational Age (birth weight ≤ 10% for gestational age)
●	795.8	HIV+ by EI, WB or PCR
●	779.5	Drug Withdrawal Syndrome in Newborn

Socio-Environmental Conditions Present in the Family (Any 1)

V19.2	Family History of Hearing Impairment
V61.5	Multiparty in Mother <20 Years (more than 3 pregnancies)
V61.21	Previous or Current Child Protective Services/Foster Care
V61.8	History of Family Violence
V62.89	Difficulty Parenting Due to Lack of Family/Social Support
V61.20	Questionable Mother/Child Attachment
V61.7	Abortion Sought or Attempted this Pregnancy
V61.4	Maternal Substance Abuse (alcohol, street, prescription or OTC drugs as documented by self-report, drug screen or court record)
V60.0	Homelessness
V17.0	Maternal Mental Illness, Especially Depression
V18.4	Maternal Mental Retardation
V16-V19	Maternal Physical Illness or Disability Affecting Care of Child
V60.2	Inadequate Material Resources Affecting Care of Child
V62.5	Parental Incarceration
XXX.16	Three or More Injuries in 1 Year Requiring Medical Attention
XXX.06	Other Maternal Conditions Significantly Affecting Care of Child
	Specify _____

SECTION D — SIGNATURES

Name of Person Completing Form Agency Phone Date

Parent Signature (encouraged but not required for referral) Parent Informed of Referral? Yes/No

Child's Name: | **Mother's Name**:

SECTION E — **LEVEL 2 RISK CONDITIONS**

(Circle all that apply) — **(Medical/Biological Conditions Present in Child Indicating Referral to Public or Private Sector Care)**

Conditions Identified in Newborn Period

● 👂	765.0	Birth weight ≤1000gms (2lbs. 3oz.)
● 👂	765.14-765.15	Birth weight ≤ 1500 Grams (3lbs. 5oz.) and > 1000gms
●	770.9	Significant Respiratory Distress (vent. > 48hrs)
● 👂	768.5	Apgar ≤ 3 at 5 Minutes (asphyxia)
●◘	772.1	Intraventricular Hemorrhage (IVH) Grade III or IV
●◘	434.9	Periventricular Leukomalacia (PVL)
● 👂	774.6	Hyperbilirubinemia Requiring Exchange Transfusion
●	777.5	Necrotizing Enterocolitis Requiring Surgery
●❖	770.7	Bronchopulmonary Dysplasia
●	779.0	Seizures in Newborn
●	770.8	Apnea
●	362.21	Retinopathy of Prematurity
●	767	Injury During Perinatal Period

Serious Problems or Abnormalities of Body Systems

●❖◘ 👂	749	Cleft Palate/Lip
●❖	750-751	Digestive System
●❖	752-753	Genito-Urinary System
●❖	745-747	Heart/Circulatory System
● 👂	744	Head, Ear and Neck
●❖	756	Musculoskeletal System
●❖	748	Respiratory System
❖	493	Asthma
●❖	759	Other Congenital Abnormalities

Specify Conditions for All Above

_____

_____

Congenital Infections (Documented)

●◘ 👂	771.1	Cytomegalovirus
●	774.4	Hepatitis B (Infant)
●	V02.6	Hepatitis B (Mother)
●◘ 👂	771.2	Herpes
●◘ 👂	771.0	Rubella
●◘ 👂	090	Syphilis
●◘ 👂	771.2X	Toxoplasmosis

Acquired Infections (Documented)

● 👂	323.9	Encephalitis
●◘ 👂	320	Meningitis, Bacterial
● 👂	321	Meningitis, All Other

Clinical Evidence of CNS Abnormality/Disorder

●	779.9	Abnormal Reflexes/Motor Functioning
●❖◘	343	Cerebral Palsy
●◘	740	Anencephalus
●❖◘	742.3	Hydrocephalus
●❖◘	742.1	Microcephalus
●❖◘	741	Spina Bifida/Myelomeningocele
●◘	348.3	Encephalopathy
❖◘	345	Seizure Disorder/Epilepsy

Genetic Conditions

❖◘✖	758.0	Down Syndrome
❖◘	758	Major Chromosomal Abnormality Specify_____
❖◘✖	XXX.07	Metabolic Disease Specify_____
❖✖	282	Hemoglobinopathy Specify _____

Other Significant Conditions

●◘	760.71	Fetal Alcohol Syndrome
●	783.4	Failure to Thrive/Growth Deficiency (Growth below 5th %)
❖◘ 👂	389.9	Hearing Impairment
◘❖ 👂	389.9X	Suspected Hearing Impairment
◘❖	369.9	Visual Impairment
❖	369.9X	Suspected Visual Impairment
◘	299.0	Autism
◘❖	358-359	Neuromuscular Disorder
●	779.3	Significant Feeding Problems/Reflux/Feeding Tubes
◘	315.9	Developmental Delay
◘	315.9X	Suspected Developmental Delay
◘	315.3	Speech/Language Delay
♥❖	984	Lead Level ≥ 20ug/dl (Venous) Specify_____
♥	984.X	Lead Level ≥ 10 <20 ug/dl (Venous) Specify_____
👂	960.6 –960.8	Ototoxic medications
👂	854.00	Head Trauma
👂	382.9	Recurrent or persistent otitis media
👂	237.72	Neurofibromatosis Type II and neurodegeneration disorders
●❖	XXX.03	Other Medical Condition(s) affecting Child Specify_____

_____

SECTION F — **REFERRAL CRITERIA LEGEND**

Symbols indicate conditions addressed by the programs below. The *Children 1st* Coordinator/appropriate staff should make referrals.

- ● High Risk Infant Follow-Up if <1 year
- ✖ Genetics
- ❖ Children's Medical Services
- ♥ Lead Program
- ◘ Babies Can't Wait if <3 years
- 👂 Track/Monitor for Hearing Loss

SECTION G — **COMMENTS**

SECTION H — **FOR HEALTH DEPARTMENT USE ONLY**

Date Form Received _____

Source of Referral (*circle only 1)*:

Birth Certificate — Head Start — School
Hospital — Pre-K — Daycare Center
Physician — Parent — Public Health
DFCS — UNHS — Other _____
SSI (Supplemental Security Income)

Date Assessment Completed: _____

Referrals Resulting from Assessment

Yes No

Date of Referral Directly to PH Programs *(Level 2 only)*: _____

Reason for Discharge (*circle only 1)*:

Cannot Locate — Unresponsive
Pending in_____ — Moved out of State
Active in _____ — Moved out of Care
Inappropriate Referral
Consent Withdrawn/Refused Date: _____
Out of Service Age Group