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

Child: ______________________________
Last Name First MI

Date of Birth: ______________ Birth weight: __________

Sex: ❑ Male ❑ Female ❑ Unknown Gestational Age: __________

Select race: (Mark all that apply)
❑ White ❑ Black or African American
❑ Asian ❑ American Indian or Alaska Native
❑ Unknown ❑ Hawaiian/ Other Pacific Islander

Latino/Hispanic: ❑Yes ❑No ❑ Unknown

Hospital: ______________ Discharge Date: __________

Transfer Hospital: ______________ Discharge Date: __________

Type of Insurance: ❑ Medicaid ❑ PeachCare ❑ Private
❑ WellCare CMO ❑ Tri-Care
❑ Amerigroup CMO ❑ None
❑ PeachState CMO ❑ Unknown

Child's Insurance #: (if known) ______________

MOTHER'S INFORMATION

Mother: ______________________________
Last Name First MI Maiden

Age: ______________ Date of Birth: __________

Education: (last grade completed)

Marital Status: ❑ M ❑ NM ❑ SEP ❑ D ❑ W

Live in Partner: ❑ Yes ❑ No

Prenatal Care: ❑ 1st ❑ 2nd ❑ 3rd ❑ 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: ❑ Y ❑ N

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

____
Name

____
Street or Route

____
City State Zip

____
Phone Fax

CONTACT INFORMATION

Child Lives with: ❑ Mother ❑ Father ❑ Guardian ❑ 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: ❑ **Not Screened** ❑ **Family Refused Screening**

Equipment:

Inpatient: Date: ____/____/____ **Left:** ❑ Pass ❑ Refer **Right:** ❑ Pass ❑ Refer ❑ AOAE ❑ AABR ❑ Other

Outpatient: Date: ____/____/____ **Left:** ❑ Pass ❑ Refer **Right:** ❑ Pass ❑ Refer ❑ AOAE ❑ AABR ❑ Other

Newborn Bloodspot Metabolic Screening: ❑ Not Screened ❑ Family Refused Screening

Vaccines Given During Hospital Stay:

Hepatitis B Vaccine: (date) _______

HBIG: (date) __________

SECTION C — LEVEL 2 RISK CONDITIONS (3 OR MORE MUST BE PRESENT FOR ELIGIBILITY)

Conditions Identified at Birth

Code	Condition
655.4	❑ Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy)
765.16-765.18	❑ Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams
V23.7	❑ Insufficient Prenatal Care (Little or no prenatal care)
V23.83-V23.84	❑ Young Prima-/Multi-gravida (Maternal Age <18 years)
V62.3	❑ Education Circumstances (Maternal Education <12 Years)

Child Abuse Prevention Treatment Act (CAPTA)

All CAPTA referrals are automatic referral (Child age birth to 3 years)

Code	Condition
V60.81	❑ *Foster Care*
995.5	❑ *Child Maltreatment Syndrome (Substantiated Case)*

DFCS Referrals (no CAPTA)

Code	Condition
V60.81	❑ *Foster Care (over age 3)*
995.5	❑ *Child Maltreatment (Substantiated Case) (over age 3)*
V61.05	❑ *Unsubstantiated or sibling of victim of substantiated case (birth to 5)*
C1MD.1	❑ *Child under age 5 exhibiting physical or developmental delay*

Socio-Environmental Conditions Present in the Family

Code	Condition	Code	Condition
V17.0	❑ Psychiatric condition (Parental Mental Illness, Depression)	V18.4	❑ Mental Retardation (Parental Mental Retardation)
V60.0	❑ Lack of Housing (Homelessness)	V60.2	❑ Inadequate Material Resources (Affecting Care of Child)
V61.05	❑ Family disruption due to child in welfare custody	V61.2	❑ Parent-Child Problems (Questionable Mother/Child Attach)
V61.5	❑ Multiparity - in Mother (<20 Years of age, >3 pregnancies)	V62.0	❑ Parental Unemployment
V62.5	❑ Legal Circumstances (Parental Incarceration)	V62.8	❑ Other Psych. or Physical Stress, (History of Family Violence)

V16-V19 ❑ Family History of (**Specify**)__________________ (Illness/disability affecting care of child)

C1SEC.1 ❑ Child Injuries (>3 in 1 Year) Requiring Medical Attention **Specify**:__________________

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? ❑ Yes ❑ 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

- 042 ❑ HIV
- 090 ❑ Syphilis

Mental Disorders

- 299.00-299.01 ❑ Autistic disorder
- 315.3 ❑ Developmental speech or language disorder
- 315.9 ❑ Unspecified delay in development
- C1MD.1 ❑ Suspected Developmental Delay

Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders

- 243 ❑ Congenital hypothyroidism
- 27X.X X ❑ Disturbances of amino-acid metabolism (Metabolic disease)
  Specify(code, diagnosis):__________________

Diseases of the Blood and Blood-Forming Organs

- 282.X ❑ Hereditary hemolytic anemias
  Specify(code, diagnosis): __________________

Diseases of the Nervous System and Sense Organs

- 320 ❑ Meningitis, Bacterial
- 321 ❑ Meningitis, All Other
- 323.9 ❑ Encephalitis
- 343.1-343.9 ❑ Infantile cerebral palsy
- 345 ❑ Epilepsy/Seizure Disorder
- 348.3 ❑ Encephalopathy
- 356-359 ❑ Neuromuscular Disorder
- 362.26 or 362.27 ❑ Retinopathy of Prematurity (Grades 4 or 5)
- 369.XX ❑ Blindness and low vision
  Specify (code, diagnosis):_________________
- 382.9 ❑ Unspecified otitis media – chronic (recurrent or persistent)
- 389.XX ❑ Hearing Loss
  Specify(code, diagnosis): _________________
- C1DNS.1 ❑ Suspected Hearing Impairment

Serious Problems or Abnormalities of Body Systems

- 390 – 459 ❑ Heart/Circulatory System
- 460 – 519 ❑ Respiratory System
- 493 ❑ Asthma
- 520 – 579 ❑ Digestive System
- 580 – 629 ❑ Genito-Urinary System
- 710 – 739 ❑ Musculoskeletal System and Connective Tissue
- 740 – 759 ❑ Congenital anomalies
- 749 ❑ Cleft Palate/Lip

Specify Conditions for All Above (include Diagnosis Code):__________

____
____
____
____
____

Conditions Originating in the Perinatal Period

- 760.71 ❑ Fetal Alcohol Syndrome
- 764.00 ❑ Light-for-dates infant without fetal malnutrition unspecified (birth weight < 10% for gestational age)
- 764.9 ❑ Fetal Growth Retardation (Intrauterine Growth Reduction-IUGR)
- 765.01-765.03 ❑ Disorders r/t extreme immaturity of infant (BW < 999 gms)
- 765.14-765.15 ❑ Disorders r/t other preterm infants (BW 1000-1500 gms)
- 767.0 ❑ Subdural and cerebral hemorrhage due to birth trauma
- 768.5 ❑ Severe birth asphyxia (APGAR < 3 at 5 Minutes)
- 770.7 ❑ Chronic Respiratory Disease in perinatal period (Broncho-pulmonary Dysplasia)
- 770.81 or 770.82 ❑ Primary apnea or other apnea in newborn
- 770.9 ❑ Unspec. Respir. Condition of fetus/newborn (vent > 48hrs)
- 771.0 ❑ Congenital Rubella
- 771.1 ❑ Congenital cytomegalovirus infection (CMV)
- 771.2 ❑ Other congenital infection in perinatal period (Herpes Simplex-congenital, Toxoplasmosis)
- 772.13 or 772.14 ❑ Intraventricular Hemorrhage (IVH), Grade III or IV
- 774.4 ❑ Perinatal jaundice d/t hepatocellular damage (NB Hepatitis)
- 774.6 ❑ Neonatal jaundice (requiring exchange transfusion)
- 777.53 ❑ Stage III necrotizing enterocolitis in newborn
- 779.0 ❑ Convulsions in newborn
- 779.3 ❑ Feeding Problems in newborn (severe reflux/feeding tube)
- 779.5 ❑ Drug Withdrawal Syndrome in Newborn
- 779.7 ❑ Periventricular/Preventricular Leukomalacia (PVL)
- C1COP.1 ❑ NICU Stay > 5 days

Symptoms, Signs and Ill-Defined Conditions

- 783.4 ❑ Failure to Thrive/Growth Deficiency (growth below 5th %)
- 796.4 ❑ Other abnormal clinical findings
  Specify(code, diagnosis):_____________________

Injury and Poisoning

- 959.01 ❑ Other and unspecified injury to head
- 984 .0-984.9 ❑ Toxic effect of lead and its compounds, including fumes
  Lead Level > 20 µg/dl (Venous)
  Specify:_________________
  Lead Level > 10 <20 µg/dl (Venous)
  Specify:______________
- C1INJ.1 ❑ Ototoxic medications including chemotherapy

Other Significant Conditions

- V02.6 ❑ Carrier/suspected carrier of viral hepatitis (Hep. B in Mom)
- V19.2 ❑ Family history of deafness or hearing loss
- V61.41 or V61.42 ❑ Alcoholism or Substance Abuse in Family (Maternal use of street, prescription or OTC drugs via self-report, drug screen or court record)
- 237.70-237.79 ❑ Neurofibromatosis

SECTION F — REFERRAL CRITERIA LEGEND

Health Department Staff: Please see eligibility lists for Babies Can't Wait, Children's Medical Services, 1st Care, Universal Newborn Hearing Screening, 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 ___________________________