



# 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: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last Name</span> <span>First</span> <span>MI</span> </div> 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"/> Private <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span><input type="checkbox"/> WellCare CMO</span> <span><input type="checkbox"/> Tri-Care</span> </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span><input type="checkbox"/> Amerigroup CMO</span> <span><input type="checkbox"/> None</span> </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span><input type="checkbox"/> PeachState CMO</span> <span><input type="checkbox"/> Unknown</span> </div> Child's Insurance #: (if known) _____	Mother: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last Name</span> <span>First</span> <span>MI</span> <span>Maiden</span> </div> 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

<b>CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER</b> Name _____ Street or Route _____ City _____ State _____ Zip _____ Phone _____ Fax _____	<b>CONTACT INFORMATION</b> Child Lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent Child's Address: _____ <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span>Street /Route</span> <span>Apt Complex # / Mobile Hm Park#</span> </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span>City</span> <span>County</span> <span>Zip</span> </div> Phone #: _____ Emergency Contact #: _____ Caregiver email address: _____
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### SECTION B HOSPITAL INFORMATION

<b>Newborn Hearing Screening:</b> <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening <b>Inpatient:</b> 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 <b>Outpatient:</b> 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	<b>Equipment:</b> <input type="checkbox"/> AOE <input type="checkbox"/> AABR <input type="checkbox"/> Other	<b>Vaccines Given During Hospital Stay:</b> <b>Hepatitis B Vaccine:</b> (date) _____ <b>HBIG:</b> (date) _____
Newborn Bloodspot Metabolic Screening: <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening		

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

<b>Conditions Identified at Birth</b> 655.4 <input type="checkbox"/> Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy) 765.16-765.18 <input type="checkbox"/> Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams V23.7 <input type="checkbox"/> Insufficient Prenatal Care (Little or no prenatal care) V23.83-V23.84 <input type="checkbox"/> Young Prima-/Multi-gravida (Maternal Age <18 years) V62.3 <input type="checkbox"/> Education Circumstances (Maternal Education <12 Years)	<b>Child Abuse Prevention Treatment Act (CAPTA)</b> <b>All CAPTA referrals are automatic referral (Child age birth to 3 years)</b> V60.81 <input type="checkbox"/> Foster Care 995.5 <input type="checkbox"/> Child Maltreatment Syndrome (Substantiated Case) <b>DFCS Referrals (no CAPTA)</b> V60.81 <input type="checkbox"/> Foster Care (over age 3) 995.5 <input type="checkbox"/> Child Maltreatment (Substantiated Case) (over age 3) V61.05 <input type="checkbox"/> Unsubstantiated or sibling of victim of substantiated case (birth to 5) C1MD.1 <input type="checkbox"/> Child under age 5 exhibiting physical or developmental delay
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<b>Socio-Environmental Conditions Present in the Family</b>	
V17.0 <input type="checkbox"/> Psychiatric condition (Parental Mental Illness, Depression) V60.0 <input type="checkbox"/> Lack of Housing (Homelessness) V61.05 <input type="checkbox"/> Family disruption due to child in welfare custody V61.5 <input type="checkbox"/> Multiparity - in Mother (<20 Years of age, >3 pregnancies) V62.5 <input type="checkbox"/> Legal Circumstances (Parental Incarceration) V16-V19 <input type="checkbox"/> Family History of (Specify) _____ (Illness/disability affecting care of child) C1SEC.1 <input type="checkbox"/> Child Injuries (>3 in 1 Year) Requiring Medical Attention Specify: _____	V18.4 <input type="checkbox"/> Mental Retardation (Parental Mental Retardation) V60.2 <input type="checkbox"/> Inadequate Material Resources (Affecting Care of Child) V61.2 <input type="checkbox"/> Parent-Child Problems (Questionable Mother/Child Attach) V62.0 <input type="checkbox"/> Parental Unemployment V62.8 <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	Form #3267 Page 1 of 2		

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 \_\_\_\_\_