



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.

For office Use Only: Referral Source: _____ Date Received: _____ Date Routed to BCW (if applicable): _____

SECTION A CHILD AND FAMILY INFORMATION	
CHILD'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 Child's Insurance #: (if known) _____ <input type="checkbox"/> None	MOTHER'S INFORMATION 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	CONTACT INFORMATION 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: _____
CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER Name _____ Street or Route _____ City State Zip Phone Fax	
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"/> ABR <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"/> ABR <input type="checkbox"/> Other Newborn Bloodspot Metabolic Screening: <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening	Equipment: 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 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)	Child Abuse Prevention Treatment Act (CAPTA) All CAPTA referrals are automatic referral (Child age birth to 3 years) Z62.21 - Z62.29 <input type="checkbox"/> Foster Care Y07.11 - Y07.0, T74.12XA - T <input type="checkbox"/> Child Maltreatment Syndrome (Substantiated Case) DFCS Referrals (no CAPTA) 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? ☐ Yes ☐ 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	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 F84.0 <input type="checkbox"/> Autistic disorder F80.9 <input type="checkbox"/> Developmental speech or language disorder F84.8 <input type="checkbox"/> Unspecified delay in development F84.9 or F89 <input type="checkbox"/> Suspected Developmental Delay	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 E03.1 - E00.9 <input type="checkbox"/> Congenital hypothyroidism E70, E71.X - E72.X <input type="checkbox"/> Disturbances of amino-acid metabolism (Metabolic disease) E70 - E88 E00 - E89 Specify(code, diagnosis): _____	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 D5X.X <input type="checkbox"/> Hereditary hemolytic anemias Specify(code, diagnosis): _____	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 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 Specify (code, diagnosis): _____ H66.X <input type="checkbox"/> Unspecified otitis media – chronic (recurrent or persistent) H90.X - H91 <input type="checkbox"/> Hearing Loss Specify(code, diagnosis): _____ C1DNS.1 <input type="checkbox"/> Suspected Hearing Impairment	Symptoms, Signs and Ill-Defined Conditions P92.6 <input type="checkbox"/> Failure to Thrive/Growth Deficiency (growth below 5th %) R68.89 <input type="checkbox"/> Other abnormal clinical findings Specify(code, diagnosis): _____
Serious Problems or Abnormalities of Body Systems 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 Specify Conditions for All Above (include Diagnosis Code): _____	Injury and Poisoning 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 > 3.5 µg/dl (Venous) Specify: _____ 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 COMMENTS

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

Email this form to your county/district Children 1st Coordinator by clicking the "Email Form" below. You can find your coordinator using the "Coordinator LookUp" button.