GEORGIA DEPARTMENT OF PUBLIC HEALTH

Niños primero

Formulario de evaluación y referido

Instrucciones: Por favor, complete el formulario para cada niño, de 5 años o menos, que padezca cualquiera de las afecciones mencionadas en la página 1 o 2. Marque o complete la mayor cantidad de información posible. Envíe el formulario al coordinador del Children 1st local.

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

SECCIÓN A — INFORMACIÓN DEL NIÑO Y DE LA FAMILIA

INFORMACIÓN DEL NIÑO

Niño: _____
Apellido Nombre Inicial del segundo nombre

Fecha de nacimiento: _____ Peso al nacer: _____

Sexo: Masculino Femenino Desconocido Edad gestacional:

Seleccione la raza: (Marque todas las opciones que apliquen)

- ❑ Blanco
- ❑ Negro o afroamericano
- ❑ Asiático
- ❑ Indio americano o nativo de Alaska
- ❑ Desconocida
- ❑ Hawaiian/ Other Pacific Islander

Latino o hispano: ❑Sí ❑No ❑ Desconocida

Hospital: _____ Fecha del alta: _____

Hospital al que fue transferido: _____ Fecha del alta: _____

Tipo de seguro:
- ❑ Medicaid
- ❑ WellCare CMO
- ❑ Amerigroup CMO
- ❑ PeachCare
- ❑ PeachState CMO
- ❑ Tri-Care
- ❑ CareSource
- ❑ Privado
- ❑ Desconocido
- ❑ Ninguno

Número del seguro del niño: (si se conoce) _____

NECESIDADES EN CUANTO AL IDIOMA

Idioma principal: _____ Se requieren lo servicios de un traductor o intérprete: ❑ S ❑ N

INFORMACIÓN DEL LA MADRE

Madre: _____
Apellido Nombre Inicial del segundo nombre Apellido de soltera

Edad: _____ Fecha de nacimiento: _____

Escolaridad: (último grado que completó)

Estado civil: ❑ C ❑ NC ❑ SEP ❑ D ❑ V

Vive en pareja: ❑ Sí ❑ No

Atención prenatal: (trimestre) ❑ 1er ❑ 2do ❑ 3er ❑ Ninguna

Paridad G:___ P:___ Pre término:___ AB: Electivo o espontáneo ___ /___ :

Número de Medicaid de los padres: _____

INFORMACIÓN DEL PADRE

_____
Apellido Nombre Inicial del segundo nombre

REFERENCIAS A CUIDADO DE TUTOR O PADRE ADOPTIVO

_____
Apellido del tutor o padre adoptivo Nombre Número de teléfono

_____
Apellido del trabajador del caso (DFCS) Nombre Número de teléfono e fax

PROFESIONAL DE ATENCIÓN MÉDICA O DE SALUD PRIMARIA DEL NIÑO

_____
Nombre

_____
Calle o ruta

_____
Ciudad Estado Código postal

_____
Número de teléfono Número de fax

INFORMACIÓN DE CONTACTO

El niño vive con: ❑ Madre ❑ Padre ❑ Tutor ❑ Padre adoptivo

Dirección del niño: _____
Calle o ruta No. de apartamento

_____
Ciudad Condado Código postal

Número de teléfono: _____ Número de emergencias: _____

Dirección de correo electrónico: _____

SECTION B — HOSPITAL INFORMATION

Newborn Hearing Screening: ❑ **Not Screened** ❑ **Family Refused Screening**

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

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 ❑ Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy)

P08.00 - P07.18 ❑ Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams

O09.30 - O09.33 ❑ Insufficient Prenatal Care (Little or no prenatal care)

O09.611 - O09.629 ❑ Young Prima-/Multi-gravida (Maternal Age <18 years)

O09.70 O09.73 ❑ 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 ❑ *Foster Care*

Y07.11 - Y07.0, T74.12XA - T ❑ *Child Maltreatment Syndrome (Substantiated Case)*

DFCS Referrals (no CAPTA)

Z62.21 - Z62.29, Y07.9 - Y07.11 ❑ *Foster Care (over age 3)*

T74.12A - T74.32XS ❑ *Child Maltreatment Substantiated Case (over age 3)*

T76.12XA - T76.32XS ❑ *Unsubstantiated or sibling of victim of substantiated case (birth to 5)*

F80.X - F89, Z00.70 - Z00.71 ❑ *Child under age 5 exhibiting physical or developmental delay*

Socio-Environmental Conditions Present in the Family

Z81.8 ❑ Psychiatric condition (Parental Mental Illness, Depression)

Z59.0 ❑ Lack of Housing (Homelessness)

Z63.32 ❑ Family disruption due to child in welfare custody

Z64.1 ❑ Multiparity - in Mother (<20 Years of age, >3 pregnancies)

Z65.3 ❑ Legal Circumstances (Parental Incarceration)

Z80.0 - Z84.89 ❑ Family History of (**Specify**)_____(Illness/disability affecting care of child)

T14.90 / T14.8 ❑ Child Injuries (>3 in 1 Year) Requiring Medical Attention **Specify**:_____

Z81.0 ❑ Mental Retardation (Parental Mental Retardation)

Z59.5 ❑ Inadequate Material Resources (Affecting Care of Child)

Z62.898/F94.2 ❑ Parent-Child Problems (Questionable Mother/Child Attach)

Z56.0 ❑ Parental Unemployment

Z63.79 ❑ 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

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

B20	❑ HIV
A50.9	❑ Syphilis

Mental Disorders

F84.0	❑ Autistic disorder
F80.9	❑ Developmental speech or language disorder
F84.8	❑ Unspecified delay in development
F84.9 or F89	❑ Suspected Developmental Delay

Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders

E03.1 - E00.9	❑ Congenital hypothyroidism
E70, E71.X - E72.X E70 - E88 E00 - E89	❑ Disturbances of amino-acid metabolism (Metabolic disease) Specify(code, diagnosis):_____

Diseases of the Blood and Blood-Forming Organs

D5X.X	❑ Hereditary hemolytic anemias Specify(code, diagnosis): _____

Diseases of the Nervous System and Sense Organs

G00.9	❑ Meningitis, Bacterial
G03.9	❑ Meningitis, All Other
G04.90	❑ Encephalitis
G80.9	❑ Infantile cerebral palsy
G40.901 - GG93.919	❑ Epilepsy/Seizure Disorder
G93.41 - G93.49 or 167.83	❑ Encephalopathy
G60.0 - G60.9 or G61.0 or G71.2	❑ Neuromuscular Disorder
H35.159 or H35.169	❑ Retinopathy of Prematurity (Grades 4 or 5)
H54.0 or H35.169	❑ Blindness and low vision **Specify (code, diagnosis):**_____
H66.X	❑ Unspecified otitis media – chronic (recurrent or persistent)
H90.X - H91	❑ Hearing Loss **Specify(code, diagnosis):** _____
C1DNS.1	❑ Suspected Hearing Impairment

Serious Problems or Abnormalities of Body Systems

100 - 195	❑ Heart/Circulatory System
J00 - J86.9	❑ Respiratory System
J45.20 - J45.22	❑ Asthma
K00 - K90.9	❑ Digestive System
N00.0 - N94.9	❑ Genito-Urinary System
M32.10 - M36.8	❑ Musculoskeletal System and Connective Tissue
Q00.0 - Q99.9	❑ Congenital anomalies
Q00.0	❑ Anencephaly
Q05.0 - Q05.9 or Q04.5	❑ Spina Bifida/Myelomeningocele
Q02	❑ Microcephaly
Q03.8 or Q3.9	❑ Hydrocephaly
Q35.9	❑ Cleft Palate/Lip

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

_____

Conditions Originating in the Perinatal Period

P04.3 or Q86.0	❑ Fetal Alcohol Syndrome
P05.00 - P05.10	❑ Light-for-dates infant without fetal malnutrition unspecified (birth weight < 10% for gestational age)
P05.X	❑ Fetal Growth Retardation (Intrauterine Growth Reduction-IUGR)
P07.00 - P07.03	❑ Disorders r/t extreme immaturity of infant (BW < 999 gms)
P07.10-P07.16	❑ Disorders r/t other preterm infants (BW 1000-1500 gms)
P10.0	❑ Subdural and cerebral hemorrhage due to birth trauma
P84	❑ Severe birth asphyxia (APGAR < 3 at 5 Minutes)
P27.0-P27.8	❑ Chronic Respiratory Disease in perinatal period (Broncho-pulmonary Dysplasia)
P28.3	❑ Primary apnea or other apnea in newborn
P28.9	❑ Unspec. Respir. Condition of fetus/newborn (vent > 48hrs)
P35.0	❑ Congenital Rubella
P35.1	❑ Congenital cytomegalovirus infection (CMV)
P35.2 or P37.X	❑ Other congenital infection in perinatal period (Herpes Simplex-congenital, Toxoplasmosis)
P52.21-P52.22	❑ Intraventricular Hemorrhage (IVH), Grade III or IV
P52.3 or P59.X	❑ Perinatal jaundice d/t hepatocellular damage (NB Hepatitis)
P59.9	❑ Neonatal jaundice (requiring exchange transfusion)
P77.3	❑ Stage III necrotizing enterocolitis in newborn
P90	❑ Convulsions in newborn
P92.8-P92.9	❑ Feeding Problems in newborn (severe reflux/feeding tube)
P96.1-P96.2	❑ Drug Withdrawal Syndrome in Newborn
P91.2	❑ Periventricular/Preventricular Leukomalacia (PVL)
C1COP.1	❑ NICU Stay > 5 days

Symptoms, Signs and Ill-Defined Conditions

P92.6	❑ Failure to Thrive/Growth Deficiency (growth below 5th %)
R68.89	❑ Other abnormal clinical findings **Specify(code, diagnosis)**:_____

Injury and Poisoning

S09.8XXA or S09.90XA	❑ Other and unspecified injury to head
T56.0XXX	❑ Toxic effect of lead and its compounds, including fumes Lead Level > 3.5 µg/dl (Venous) **Specify**:_____
C1INJ.1	❑ Ototoxic medications including chemotherapy

Other Significant Conditions

Z20.5 - Z22.52	❑ Carrier/suspected carrier of viral hepatitis (Hep. B in Mom)
Z82.2	❑ Family history of deafness or hearing loss
Z63.72	❑ Alcoholism or Substance Abuse in Family (Maternal use of street, prescription or OTC drugs via self-report, drug screen or court record)
Q85.0X	❑ Neurofibromatosis

Sección F — Comentarios

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

Envíe este formulario por correo electrónico al coordinador del Children 1st de su condado o distrito. Presione «Enviar formulario por correo electrónico» a continuación. Utilice el botón «Búsqueda de coordinador» para buscar a su coordinador.

Enviar formulario por correo electrónico

Búsqueda de coordinador