Guidelines - Children 1st Screening and Referral Form

The Children 1st Screening and Referral form can be completed by any person who has a concern regarding a child's health and/or development. The referral source should complete as much information as possible. Completed Children 1st Screening and Referral forms are sent to the Children 1st District Coordinator for processing and follow-up. To learn more about Children 1st eligibility, services, and resources, visit dph.georgia.gov/children1st.

SECTION A: CHILD AND FAMILY INFORMATION

CHILD'S INFORMATION

Name of Child - Enter last name on birth certificate, first name, and middle initial.

Date of Birth - Indicate month, date, and year of birth of the child.

Birth Weight - Indicate child's birth weight.

Sex of Child - Check if child is male, female or sex is unknown.

Gestational Age - Indicate number of weeks gestation at time of birth.

Select race - Check all applicable races of child based on parent report. A multiracial child should have more than one box marked.

Latino/Hispanic - Check **yes, no, or unknown** to indicate if child is of Latino or Hispanic descent, based on parent report.

Hospital - **I**ndicate name of hospital of delivery.

Discharge Date - Indicate date child was discharged from hospital of delivery.

Transfer Hospital - Indicate name of hospital child was transferred to after delivery, if applicable.

Discharge Date - Indicate date child was discharged from transfer hospital.

Type of Insurance – Check the child's type of insurance coverage. If Medicaid or PeachCare is selected, indicate by check if the child is enrolled in a Managed Care Organization, if known.

Child's Insurance # - List child's Medicaid, PeachCare, or insurance number if known.

LANGUAGE NEEDS

Primary Language - List the primary language spoken by mother.

Translator Needed - Check **yes** or **no** to indicate if a translator or interpreter is needed for family.

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

Primary Health Care Provider Information - Indicate name of primary care provider, address,

phone, and fax number. Include area codes.

MOTHER AND FATHER'S INFORMATION

Name of Mother - Enter last name, first name, middle initial, and maiden name.

Age - Indicate age of mother at time of referral.

Date of Birth – Indicate the mom's month, date, and year of birth.

Education - Indicate highest level of education completed.

Marital Status - Check marital status. M – Married, NM – Never Married, SEP – Married but Separated, D – Divorced and not remarried, W – Widowed and not remarried**.**

Live in Partner - Check **yes** or **no** to indicate if mother is living with a partner.

Prenatal Care - Check trimester (**1st, 2nd** or **3rd**) mother began to receive prenatal care for this pregnancy. If mother did not receive any prenatal care, check **none**.

Parity G/Gravida - Indicate number of pregnancies.

Parity P/Para - Indicate number of live births.

Pre-Term - Indicate number of pre-term births.

AB: E/S - Indicate number of **E** - **Elective** abortions and the number of **S** - **Spontaneous** abortions.

Parent's Medicaid # - List Medicaid number of mother, if known.

Name of Father - Enter last name, first name, and middle initial.

GUARDIAN/FOSTER CARE REFERRALS

Guardian/ Foster Parent - List name and telephone number of Guardian or Foster Parent, if different from above information about mother. Use **Section G**, **Comments**, to list primary language spoken by guardian and if a translator is needed.

DFCS Case Worker List last name, first name, office phone number, and fax number of assigned DFCS Case Worker.

CONTACT INFORMATION

Child Lives with - Indicate if child lives mother, father, guardian, or foster parent.

Child's Address - Enter street address of child. Include city, county, and zip code of residence. If a child lives with someone other than the birth mother, the child's residence should be listed here and indicate with whom the child resides.

Phone # - List home or primary phone number with area code of the child's primary caregiver.

Emergency Contact # - List cellular or alternate number of parent, neighbor, relative or friend where family can be reached in emergency; including area codes.

Caregiver Email Address - Include an email address for the primary caregiver of the child.

SECTION B: HOSPITAL INFORMATION

Newborn Hearing Screening - Check **Not Screened** if the newborn did not receive a hearing screening before hospital discharge. Check **Family Refused Screening** if family chose not to have newborn screened. Indicate date of screening. Check **pass** or **refer** result for each ear (L = Left, R = Right) of the **outpatient** and**/**or **inpatient** screening(s). Check the type of equipment used for the screening: **AOAE**, **AABR** or **Other**.

Vaccines Given During Hospital Stay - Indicate the date of administration of Hepatitis B Vaccine and/or Hepatitis B Immune Globulin provided to child.

Newborn Bloodspot Metabolic Screening - Check **Not Screened** if newborn did not receive a metabolic screening before hospital discharge. Check **Family Refused Screening** if family chose not to have newborn screened.

SECTION C: LEVEL 2 RISK CONDITIONS

CONDITIONS IDENTIFIED AT BIRTH

P01.0 - P04.9: Suspected damage to fetus. Check box if birth mother reported she smoked or drank greater than 7 drinks per week during pregnancy.

P08.00 - P07.18: Disorders r/t other preterm infants <2500 grams and > 1500 Grams. Check box if the infant was born weighing less than 2500 grams (5 pounds, 8 ounces) or greater than 1500 grams (3 pounds, 5 ounces).

O09.30 - O09.33: Insufficient Prenatal Care. Check box if mother received little or no prenatal care as evidenced by no second or third trimester care or fewer than 5 prenatal visits.

O09.611 - O09.629: Young Prima-/Multi-gravida. Check box if birth mother was under the age of 18 at the time of the child's birth.

O09.70 O09.73: Education Circumstances. Check box if birth mother had less than 12 years of education at the time of the child's birth.

Yellow Shaded Box: Division of Family and Children Services Referrals Only

Child Abuse Prevention Treatment Act (CAPTA) – Child birth to age 3 years with a case of substantiated abuse or neglect. Check if child is in Foster Care. If child is substantiated but not in Foster Care, check Child Maltreatment Syndrome (Substantiated Case**)**

DFCS Referrals (not CAPTA) – Child age 3 to age 5 years that is in Foster Care or Substantiated

Case or Unsubstantiated Case birth to age 5 years. Check one of the following:

- Foster Care (over age 3)
- Child Maltreatment (Substantiated Case) (over age 3)
- Unsubstantiated or sibling of victim of substantiated case (birth to age 5)
- Child under age 5 exhibiting physical or developmental delay.

NOTE: If child also has a diagnosed medical condition under Level 1 Conditions, please check all appropriate boxes on page 2 of the screening and referral form.

Socio-Environmental Conditions Present in the Family (Check all that apply)

Psychiatric condition (Parental Mental Illness, Depression), Lack of Housing (Homelessness), Family disruption due to child in welfare custody (child greater than 5 years, otherwise see yellow box above), Multiparity in Mother less than 20 years of age, Legal Circumstances (Parental Incarceration), Parental Mental Retardation, Inadequate Material Resources (Affecting Care of Child), Parent-Child Problems (Questionable Mother-Child Attachment), Parental Unemployment, Other Psychological or Physical Stress (History of Family Violence), Family History of (Specify illness or disability affecting care of child), Child Injuries (greater than or equal to three injuries per year requiring medical attention, specify injuries). **Check all boxes that apply. Three or more Level 2 conditions must be present to be eligible for Children 1st program services.**

SECTION D: SIGNATURES

Name of Person Completing Form - Indicate first/last name and title of person completing form.

Agency - Indicate referring agency of person completing form.

Phone - Indicate phone number of agency/individual.

Date - Indicate date form is completed.

Parent's Signature - If parent is present, signature representing consent for referral is encouraged, but not required.

Parent Informed of referral - Check **yes** or **no** to indicate if parent has been informed of referral.

SECTION E: LEVEL 1 RISK CONDITIONS

Medical/Biological Conditions Present in Child Indicating Referral to Public or Private Sector Care

Check **ALL** that apply under each category: Infectious and Parasitic Diseases, Mental Disorders, Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders, Diseases of Blood and Blood-Forming Organs, Diseases of the Nervous System and Sense Organs, Serious Problems or Abnormalities of Body Systems, Conditions Originating in the Perinatal Period, Symptoms, Signs and Ill-Defined Conditions, Injury and Poisoning, or Other Significant Conditions. Specify conditions and diagnosis codes, as indicated.

SECTION F: COMMENTS

Note any pertinent information about family or child that would assist the Children 1st Coordinator in supporting the family.

Developmental Screening - Check if the child has received a developmental screening within the last 4 months. If yes, indicate the agency or person completing the screen and attach the results, if available. Indicate the scores of the screen, if known.

Other (For DPH Staff only) - At top of page 1 of Screening and Referral form, indicate the source of the referral and the date received by Children 1st as the single point of entry.

ADDITIONAL DOCUMENTATION

Hospitals: Please submit discharge summaries and any other documentation related to the child's health status with the Screening and Referral form.

Pediatricians' Offices: Please submit any medical documentation related to the child's health status with the Screening and Referral form.

DFCS: Please submit any court orders and release of information documents with the Screening and Referral form.

SUBMIT THE REFERRAL

1. Complete the Children 1st Screening and Referral Form
2. Visit the Maternal and Child Health Coordinator Locator online at sendss.state.ga.us/sendss/!mch.coord_search
3. Enter in the **child's** zip code OR County
4. Enter a check mark besides the Children 1st box and select "Search for Locations"
5. Fax the Children 1st Screening and Referral form and other supporting documents to the first Children 1st Coordinator listed under results.

ORDERING ADDITIONAL FORMS

Additional forms may be obtained by contacting your local Children 1st District Coordinator. The Children 1st Screening and Referral form may also be downloaded from the Children 1st website: dph.georgia.gov/children1st.