Guidelines for Completing the Children 1st Screening and Referral Form
Revised 8/20/2012

Over the last several years, the impact of parenting, stimulation and environment on brain
development in the early years of life and on long-term child development has been well
established. For these reasons, Children 1st looks at the broad array of biological and socio-
environmental risk factors affecting the well being of a child and family. Children 1st provides a
population-based system of screening young children for specific risk conditions which place the
child at risk for adverse health and/or developmental outcomes.

Health Districts identify at-risk children by accessing State Vital Records birth data files, while
others rely on external referrals for identification of births. Both referral sources may be utilized
within a health district. The Children 1st Screening and Referral Form is a standardized form used
to identify and screen children who need further assessment and follow-up after the period of
birth and up to the fifth birthday. In addition, Children 1st helps to simplify the process of referral
to public health programs by being the single point of entry for families to connect with public
health programs and prevention based programs and services.

Once identified, each birth is screened for risk status. Children can be identified as having Level
1 and/or Level 2 conditions. Level 1 risk conditions represent a group of children needing
specific medical services and referral to public and/or private sector care agencies. Level 2 risk
conditions involve socio-environmental risks as well as certain medical/biological conditions
present in the child. In some situations, children can be identified as having both socio-
environmental and medical risks making them both Level 1 and Level 2.

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 as
possible. Completed Children 1st Screening and Referral forms are sent to the Children 1st District
Coordinator for processing and follow-up.

Section A: Child and Family Information

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Enter last name on birth certificate, first name, and middle initial.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Mother</td>
<td>Enter last name, first name, middle initial and maiden name.</td>
</tr>
<tr>
<td>Name of Father</td>
<td>Enter last name, first name, and middle initial.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Address</td>
</tr>
<tr>
<td>Phone #</td>
</tr>
<tr>
<td>Emergency Contact #</td>
</tr>
<tr>
<td>Caregiver Email Address</td>
</tr>
</tbody>
</table>
Latino/Hispanic
Check yes, no, or unknown to indicate if child is of Latino or Hispanic descent, based on parent report.

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

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

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

Birth weight
Indicate child’s birth weight.

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

Hospital
Indicate name of hospital of delivery.

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

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

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

Type of Insurance
Check type of insurance coverage for child. 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.

Mother’s Information

Age
Indicate age of mother at time of referral.

Date Of Birth
Indicate month, date and year of birth or mother.

Education
Indicate highest level of education completed.

Marital Status

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

Parity
G/Gravida - Indicate number of pregnancies.

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.

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.

Medicaid #

List Medicaid number of mother, if known.

CAPTA/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.

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.

Section B: Hospital Information

Newborn Hearing Screening

Check Not Screened if 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 (Families Offered In-Home or Clinic Assessment if three or more are present)

Conditions Identified at Birth

**655.4** Suspected damage to fetus. Check box if birth mother reported she smoked or drank greater than 7 drinks per week during pregnancy.

**765.16-765.18** 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).

**V23.7** 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.

**V23.83 – V23.84** Young Prima-/Multi-gravida. Check box if birth mother was under the age of 18 at the time of the child’s birth.

**V62.3** 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 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 G: 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.

Ordering Additional Forms
Additional forms may be obtained by contacting the Children 1st District Coordinator. A list of district coordinators can be obtained on the Children 1st website. The Children 1st Screening and Referral form may also be downloaded from the Children 1st website: http://health.state.ga.us/programs/childrenfirst/