



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

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER	CONTACT INFORMATION
Name _____ Street or Route _____ City _____ State _____ Zip _____ Phone _____ Fax _____	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;"> Street /Route Apt Complex # / Mobile Hm Park# </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> City County Zip </div> Phone #: _____ Emergency Contact #: _____ Caregiver email address: _____

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"/> AABR <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"/> AABR <input type="checkbox"/> Other Newborn Bloodspot Metabolic Screening: <input type="checkbox"/> Not Screened <input type="checkbox"/> Family Refused Screening	Equipment: <input type="checkbox"/> AOE <input type="checkbox"/> AABR <input type="checkbox"/> Other	Vaccines Given During Hospital Stay: Hepatitis B Vaccine: (date) _____ HBIG: (date) _____
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SECTION C LEVEL 2 RISK CONDITIONS (3 OR MORE MUST BE PRESENT FOR ELIGIBILITY)

Conditions Identified at Birth 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)	Child Abuse Prevention Treatment Act (CAPTA) All CAPTA referrals are automatic referral (Child age birth to 3 years) V60.81 <input type="checkbox"/> Foster Care 995.5 <input type="checkbox"/> Child Maltreatment Syndrome (Substantiated Case) DFCS Referrals (no CAPTA) 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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Socio-Environmental Conditions Present in the Family

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)
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SECTION D SIGNATURES

Name of Person Completing Form _____	Agency _____	Email Address _____	Phone _____
Parent Signature (Encouraged but not required for referral) _____	Parent Informed of Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	

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 _____