

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

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|-----------------------------------|--|
| Name of Child | Enter last name on birth certificate, first name, and middle initial. |
| Name of Mother | Enter last name, first name, middle initial and maiden name. |
| Name of Father | Enter last name, first name, and middle initial. |
| <u>Child's Information</u> | |
| 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. |
| 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. |

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| 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. |
| <u>Language Needs</u> | |
| 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. |
| <u>Mother's Information</u> | |
| Age | Indicate age of mother at time of referral. |
| Date Of Birth | Indicate month, date and year of birth of mother. |
| 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 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

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|---------------------------------------|--|
| 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/>