Georgia Department of Public Health

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

Child: _____
Last Name First MI

Date of Birth: _____ Birth weight: _____

Sex: ❑ Male ❑ Female ❑ Unknown Gestational Age: _____

Select race: (Mark all that apply)

❑ White ❑ Black or African American
❑ Asian ❑ American Indian or Alaska Native
❑ Unknown ❑ Hawaiian/ Other Pacific Islander

Latino/Hispanic: ❑Yes ❑No ❑ Unknown

Hospital: _____ Discharge Date: _____

Transfer Hospital: _____ Discharge Date: _____

Type of Insurance: ❑ Medicaid ❑ PeachCare ❑ Private
❑ WellCare CMO ❑ Tri-Care
❑ Amerigroup CMO ❑ None
❑ PeachState CMO ❑ Unknown

Child's Insurance #: (if known) _____

LANGUAGE NEEDS

Primary Language: _____ Translator/Interpreter Needed: ❑ Y ❑ N

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

_____
Name

_____
Street or Route

_____
City State Zip

_____
Phone Fax

MOTHER'S INFORMATION

Mother: _____
Last Name First MI Maiden

Age: _____ Date of Birth: _____

Education: (last grade completed)

Marital Status: ❑ M ❑ NM ❑ SEP ❑ D ❑ W

Live in Partner: ❑ Yes ❑ No

Prenatal Care: ❑ 1st ❑ 2nd ❑ 3rd ❑ 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

CONTACT INFORMATION

Child Lives with: ❑ Mother ❑ Father ❑ Guardian ❑ Foster Parent

Child's Address: _____
Street /Route Apt Complex # / Mobile Hm Park#

_____
City County Zip

Phone #: _____ Emergency Contact #: _____

Caregiver email address: _____

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

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

765.16-765.18 ❑ Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams

V23.7 ❑ Insufficient Prenatal Care (Little or no prenatal care)

V23.83-V23.84 ❑ Young Prima-/Multi-gravida (Maternal Age <18 years)

V62.3 ❑ 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 ❑ *Foster Care*

995.5 ❑ *Child Maltreatment Syndrome (Substantiated Case)*

DFCS Referrals (no CAPTA)

V60.81 ❑ *Foster Care (over age 3)*

995.5 ❑ *Child Maltreatment (Substantiated Case) (over age 3)*

V61.05 ❑ *Unsubstantiated or sibling of victim of substantiated case (birth to 5)*

C1MD.1 ❑ *Child under age 5 exhibiting physical or developmental delay*

Socio-Environmental Conditions Present in the Family

V17.0 ❑ Psychiatric condition (Parental Mental Illness, Depression)

V60.0 ❑ Lack of Housing (Homelessness)

V61.05 ❑ Family disruption due to child in welfare custody

V61.5 ❑ Multiparity - in Mother (<20 Years of age, >3 pregnancies)

V62.5 ❑ Legal Circumstances (Parental Incarceration)

V16-V19 ❑ Family History of (**Specify**)_____ (Illness/disability affecting care of child)

C1SEC.1 ❑ Child Injuries (>3 in 1 Year) Requiring Medical Attention **Specify**:_____

V18.4 ❑ Mental Retardation (Parental Mental Retardation)

V60.2 ❑ Inadequate Material Resources (Affecting Care of Child)

V61.2 ❑ Parent-Child Problems (Questionable Mother/Child Attach)

V62.0 ❑ Parental Unemployment

V62.8 ❑ 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

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 _____