



DIRECTIONS: Please complete form on every child, birth to age 5, having any of the conditions listed on 1st or 2nd page. Circle or fill in as much information as possible. Send form to local *Children 1st* Coordinator.

Screening and Referral Form

SECTION A CHILD AND FAMILY INFORMATION

Child:	Mother:	Father:
Last Name First MI	Last Name First MI Maiden	Last Name First MI

CHILD'S INFORMATION	MOTHER'S INFORMATION
Child's Address Street/Route Apt Complex # / Mobile Hm Park # _____ City County Zip _____ Phone # _____ Emergency Contact # _____ Directions to Home _____ _____ Latino/Hispanic: Y/N/UNK Select one race: (1) White (2) Black or African American (3) American Indian or Alaska Native (4) Asian (5) Hawaiian or Other Pacific Islander (6) Multiracial (7) Unknown Sex: Male Female Unknown Date of Birth _____ Birth weight _____ Gestational Age _____ Hospital _____ Discharge Date _____ Transfer Hospital _____ Discharge Date _____ Type of Insurance: Private Tri-Care PeachCare Medicaid None/Unknown Medicaid # (if known) _____	Age _____ Date of Birth _____ Education (last grade completed) _____ Marital Status (circle only I): M NM SEP D W Live in Partner: Y/N Parity G: ___ P: ___ Pre-Term: ___ AB: Elective/Spontaneous ___ / ___ Prenatal Care 1st 2nd 3rd None Medicaid # _____
GUARDIAN/FOSTER PARENT (If different from above)	
Last Name First MI	
CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER	
Name _____	
Street or Route _____	
City State Zip	
Phone Fax	

LANGUAGE NEEDS

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

SECTION B HOSPITAL INFORMATION

Newborn Hearing Screening: Not screened Family Refused Screening Inpatient: Date: ___/___/___ L: Passed/Referred R: Passed/Referred Equipment: AOAE AABR Other Outpatient: Date: ___/___/___ L: Passed/Referred R: Passed/Referred Equipment: AOAE AABR Other	Vaccines Given During Hospital Stay: Hepatitis B Vaccine (date) _____ HBIG (date) _____
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SECTION C LEVEL 1 RISK CONDITIONS (Families Offered In-Home Assessment)

Conditions Identified at Birth	Socio-Environmental Conditions Present in the Family (Any 1)
XXX.11 Negative Family Index (includes XXX.12, V62.3 & V62.9) XXX.12 Maternal Age <20 years V62.3 Maternal Education <12 Years V62.9 No Father's Name on Birth Certificate XXX.13 Negative Healthy Start Index (765, V23.7, & XXX.17) 765 Birth weight <2500 Grams (5 lbs. 8 oz.) V23.7 No 1st Trimester Prenatal Care XXX.17 Mother Smoked and/or Drank (> 7 drinks/week) during Pregnancy XXX.14 2 or More of the 6 Risk Conditions Listed Above Medical/Biological Conditions Present in the Child (Any 1) ● XXX.15 Special Care Nursery >48 hours (specify medical conditions on back) ● 764.9 Small for Gestational Age (birth weight ≤ 10% for gestational age) ● 795.8 HIV+ by EI, WB or PCR ● 779.5 Drug Withdrawal Syndrome in Newborn	V19.2 Family History of Hearing Impairment V61.5 Multiparity in Mother <20 Years (more than 3 pregnancies) V61.21 Previous or Current Child Protective Services/Foster Care V61.8 History of Family Violence V62.89 Difficulty Parenting Due to Lack of Family/Social Support V61.20 Questionable Mother/Child Attachment V61.7 Abortion Sought or Attempted this Pregnancy V61.4 Maternal Substance Abuse (alcohol, street, prescription or OTC drugs as documented by self-report, drug screen or court record) V60.0 Homelessness V17.0 Maternal Mental Illness, Especially Depression V18.4 Maternal Mental Retardation V16-V19 Maternal Physical Illness or Disability Affecting Care of Child V60.2 Inadequate Material Resources Affecting Care of Child V62.5 Parental Incarceration XXX.16 Three or More Injuries in 1 Year Requiring Medical Attention XXX.06 Other Maternal Conditions Significantly Affecting Care of Child Specify _____

SECTION D SIGNATURES

Name of Person Completing Form	Agency	Phone	Date
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Parent Signature (encouraged but not required for referral) _____ Parent Informed of Referral? Yes/No

