



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.

For office Use Only: Referral Source: _____ Date Received: _____ Date Routed to BCW (if applicable): _____

SECTION A CHILD AND FAMILY INFORMATION

CHILD'S INFORMATION	MOTHER'S INFORMATION
Child: _____ Last Name First MI 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"/> CareSource <input type="checkbox"/> WellCare CMO <input type="checkbox"/> PeachState CMO <input type="checkbox"/> Private <input type="checkbox"/> Amerigroup CMO <input type="checkbox"/> Tri-Care <input type="checkbox"/> Unknown <input type="checkbox"/> None Child's Insurance #: (if known) _____	Mother: _____ Last Name First MI Maiden 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

Name _____ Street or Route _____ City _____ State _____ Zip _____ Phone _____ Fax _____	CONTACT INFORMATION Child Lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent Child's Address: _____ Street /Route Apt Complex # / Mobile Hm Park# _____ City County Zip Phone #: _____ Emergency Contact #: _____ Caregiver email address: _____
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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:	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 P01.0 - P04.9 <input type="checkbox"/> Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy) P08.00 - P07.18 <input type="checkbox"/> Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams O09.30 - O09.33 <input type="checkbox"/> Insufficient Prenatal Care (Little or no prenatal care) O09.611 - O09.629 <input type="checkbox"/> Young Prima-/Multi-gravida (Maternal Age <18 years) O09.70 O09.73 <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) Z62.21 - Z62.29 <input type="checkbox"/> Foster Care Y07.11 - Y07.0, T74.12XA - T <input type="checkbox"/> Child Maltreatment Syndrome (Substantiated Case) DFCS Referrals (no CAPTA) Z62.21 - Z62.29, Y07.9 - Y07.11 <input type="checkbox"/> Foster Care (over age 3) T74.12A - T74.32XS <input type="checkbox"/> Child Maltreatment Substantiated Case (over age 3) T76.12XA - T76.32XS <input type="checkbox"/> Unsubstantiated or sibling of victim of substantiated case (birth to 5) F80.X - F89, Z00.70 - Z00.71 <input type="checkbox"/> Child under age 5 exhibiting physical or developmental delay
Socio-Environmental Conditions Present in the Family	
Z81.8 <input type="checkbox"/> Psychiatric condition (Parental Mental Illness, Depression) Z59.0 <input type="checkbox"/> Lack of Housing (Homelessness) Z63.32 <input type="checkbox"/> Family disruption due to child in welfare custody Z64.1 <input type="checkbox"/> Multiparity - in Mother (<20 Years of age, >3 pregnancies) Z65.3 <input type="checkbox"/> Legal Circumstances (Parental Incarceration) Z80.0 - Z84.89 <input type="checkbox"/> Family History of (Specify) _____ (Illness/disability affecting care of child) T14.90 / T14.8 <input type="checkbox"/> Child Injuries (>3 in 1 Year) Requiring Medical Attention Specify: _____	Z81.0 <input type="checkbox"/> Mental Retardation (Parental Mental Retardation) Z59.5 <input type="checkbox"/> Inadequate Material Resources (Affecting Care of Child) Z62.898/F94.2 <input type="checkbox"/> Parent-Child Problems (Questionable Mother/Child Attach) Z56.0 <input type="checkbox"/> Parental Unemployment Z63.79 <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Form #3267 Page 1 of 2		

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

- B20 HIV
A50.9 Syphilis

Mental Disorders

- F84.0 Autistic disorder
F80.9 Developmental speech or language disorder
F84.8 Unspecified delay in development
F84.9 or F89 Suspected Developmental Delay

Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders

- E03.1 - E00.9 Congenital hypothyroidism
E70, E71.X - E72.X Disturbances of amino-acid metabolism (Metabolic disease)
E70 - E88
E00 - E89 Specify(code, diagnosis):

Diseases of the Blood and Blood-Forming Organs

- D5X.X Hereditary hemolytic anemias
Specify(code, diagnosis):

Diseases of the Nervous System and Sense Organs

- G00.9 Meningitis, Bacterial
G03.9 Meningitis, All Other
G04.90 Encephalitis
G80.9 Infantile cerebral palsy
G40.901 - GG93.919 Epilepsy/Seizure Disorder
G93.41 - G93.49 or 167.83 Encephalopathy
G60.0 - G60.9 or G61.0 or G71.2 Neuromuscular Disorder
H35.159 or H35.169 Retinopathy of Prematurity (Grades 4 or 5)
H54.0 or H35.169 Blindness and low vision
Specify (code, diagnosis):
H66.X Unspecified otitis media - chronic (recurrent or persistent)
H90.X - H91 Hearing Loss
Specify(code, diagnosis):
C1DNS.1 Suspected Hearing Impairment

Serious Problems or Abnormalities of Body Systems

- 100 - 195 Heart/Circulatory System
J00 - J86.9 Respiratory System
J45.20 - J45.22 Asthma
K00 - K90.9 Digestive System
N00.0 - N94.9 Genito-Urinary System
M32.10 - M36.8 Musculoskeletal System and Connective Tissue
Q00.0 - Q99.9 Congenital anomalies
Q00.0 Anencephaly
Q05.0 - Q05.9 or Q04.5 Spina Bifida/Myelomeningocele
Q02 Microcephaly
Q03.8 or Q3.9 Hydrocephaly
Q35.9 Cleft Palate/Lip

Specify Conditions for All Above (include Diagnosis Code):

Conditions Originating in the Perinatal Period

- P04.3 or Q86.0 Fetal Alcohol Syndrome
P05.00 - P05.10 Light-for-dates infant without fetal malnutrition unspecified (birth weight < 10% for gestational age)
P05.X Fetal Growth Retardation (Intrauterine Growth Reduction-IUGR)
P07.00 - P07.03 Disorders r/t extreme immaturity of infant (BW < 999 gms)
P07.10-P07.16 Disorders r/t other preterm infants (BW 1000-1500 gms)
P10.0 Subdural and cerebral hemorrhage due to birth trauma
P84 Severe birth asphyxia (APGAR < 3 at 5 Minutes)
P27.0-P27.8 Chronic Respiratory Disease in perinatal period (Broncho-pulmonary Dysplasia)
P28.3 Primary apnea or other apnea in newborn
P28.9 Unspec. Respir. Condition of fetus/newborn (vent > 48hrs)
P35.0 Congenital Rubella
P35.1 Congenital cytomegalovirus infection (CMV)
P35.2 or P37.X Other congenital infection in perinatal period (Herpes Simplex-congenital, Toxoplasmosis)
P52.21-P52.22 Intraventricular Hemorrhage (IVH), Grade III or IV
P52.3 or P59.X Perinatal jaundice d/t hepatocellular damage (NB Hepatitis)
P59.9 Neonatal jaundice (requiring exchange transfusion)
P77.3 Stage III necrotizing enterocolitis in newborn
P90 Convulsions in newborn
P92.8-P92.9 Feeding Problems in newborn (severe reflux/feeding tube)
P96.1-P96.2 Drug Withdrawal Syndrome in Newborn
P91.2 Periventricular/Preventricular Leukomalacia (PVL)
C1COP.1 NICU Stay > 5 days

Symptoms, Signs and Ill-Defined Conditions

- P92.6 Failure to Thrive/Growth Deficiency (growth below 5th %)
R68.89 Other abnormal clinical findings
Specify(code, diagnosis):

Injury and Poisoning

- S09.8XXA or S09.90XA Other and unspecified injury to head
T56.0XXX Toxic effect of lead and its compounds, including fumes
Lead Level > 20 ug/dl (Venous)
Specify:
Lead Level > 10 <20 ug/dl (Venous)
Specify:
C1INJ.1 Ototoxic medications including chemotherapy

Other Significant Conditions

- Z20.5 - Z22.52 Carrier/suspected carrier of viral hepatitis (Hep. B in Mom)
Z82.2 Family history of deafness or hearing loss
Z63.72 Alcoholism or Substance Abuse in Family (Maternal use of street, prescription or OTC drugs via self-report, drug screen or court record)
Q85.0X Neurofibromatosis

SECTION F

COMMENTS

Has child received a recent developmental screening?: Not screened Yes, screened by (Please attach results)
Measure used: Date screening completed Scores

Email this form to your county/district Children 1st Coordinator by clicking the "Email Form" below. You can find your coordinator using the "Coordinator LookUp" button.