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

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 ❑ CareSource
❑ WellCare CMO ❑ PeachState CMO ❑ Private
❑ Amerigroup CMO ❑ Tri-Care ❑ Unknown
❑ None

Child's Insurance #: (if known) _____________________

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

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: ❑ 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**

Equipment:

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

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

Code	Condition
P01.0 - P04.9	❑ Suspected damage to fetus (Mother Smoked and/or Drank, > 7 drinks/week, during Pregnancy)
P08.00 - P07.18	❑ Disorders r/t other preterm infants <2500 Grams (5 lbs. 8 oz.) and > 1500 Grams
O09.30 - O09.33	❑ Insufficient Prenatal Care (Little or no prenatal care)
O09.611 - O09.629	❑ Young Prima-/Multi-gravida (Maternal Age <18 years)
O09.70 O09.73	❑ Education Circumstances (Maternal Education <12 Years)

Child Abuse Prevention Treatment Act (CAPTA)
All CAPTA referrals are automatic referral (Child age birth to 3 years)

Code	Condition
Z62.21 - Z62.29	❑ *Foster Care*
Y07.11 - Y07.0, T74.12XA - T	❑ *Child Maltreatment Syndrome (Substantiated Case)*

DFCS Referrals (no CAPTA)

Code	Condition
Z62.21 - Z62.29, Y07.9 - Y07.11	❑ *Foster Care (over age 3)*
T74.12A - T74.32XS	❑ *Child Maltreatment Substantiated Case (over age 3)*
T76.12XA - T76.32XS	❑ *Unsubstantiated or sibling of victim of substantiated case (birth to 5)*
F80.X - F89, Z00.70 - Z00.71	❑ *Child under age 5 exhibiting physical or developmental delay*

Socio-Environmental Conditions Present in the Family

Code	Condition	Code	Condition
Z81.8	❑ Psychiatric condition (Parental Mental Illness, Depression)	Z81.0	❑ Mental Retardation (Parental Mental Retardation)
Z59.0	❑ Lack of Housing (Homelessness)	Z59.5	❑ Inadequate Material Resources (Affecting Care of Child)
Z63.32	❑ Family disruption due to child in welfare custody	Z62.898/F94.2	❑ Parent-Child Problems (Questionable Mother/Child Attach)
Z64.1	❑ Multiparity - in Mother (<20 Years of age, >3 pregnancies)	Z56.0	❑ Parental Unemployment
Z65.3	❑ Legal Circumstances (Parental Incarceration)	Z63.79	❑ Other Psych. or Physical Stress, (History of Family Violence)
Z80.0 - Z84.89	❑ Family History of (**Specify**)__________(Illness/disability affecting care of child)		
T14.90 / T14.8	❑ Child Injuries (>3 in 1 Year) Requiring Medical Attention **Specify**:____________________		

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

Code	Condition
B20	❑ HIV
A50.9	❑ Syphilis

Mental Disorders

Code	Condition
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

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

Diseases of the Blood and Blood-Forming Organs

Code	Condition
D5X.X	❑ Hereditary hemolytic anemias Specify(code, diagnosis): __________________

Diseases of the Nervous System and Sense Organs

Code	Condition
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

Code	Condition
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

Code	Condition
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

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

Injury and Poisoning

Code	Condition
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 μg/dl (Venous) **Specify**:_______________ Lead Level > 10 <20 μg/dl (Venous) **Specify**:____________
C1INJ.1	❑ Ototoxic medications including chemotherapy

Other Significant Conditions

Code	Condition
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.