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.

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) _____

LANGUAGE NEEDS

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

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

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**

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

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)

Z62.21 - Z62.29 ❑ *Foster Care*

Y07.11 - Y07.0, T74.12XA - T ❑ *Child Maltreatment Syndrome (Substantiated Case)*

DFCS Referrals (no CAPTA)

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

Z81.8 ❑ Psychiatric condition (Parental Mental Illness, Depression)

Z59.0 ❑ Lack of Housing (Homelessness)

Z63.32 ❑ Family disruption due to child in welfare custody

Z64.1 ❑ Multiparity - in Mother (<20 Years of age, >3 pregnancies)

Z65.3 ❑ Legal Circumstances (Parental Incarceration)

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**:_____

Z81.0 ❑ Mental Retardation (Parental Mental Retardation)

Z59.5 ❑ Inadequate Material Resources (Affecting Care of Child)

Z62.898/F94.2 ❑ Parent-Child Problems (Questionable Mother/Child Attach)

Z56.0 ❑ Parental Unemployment

Z63.79 ❑ 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

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 E70 - E88 E00 - E89	❑ Disturbances of amino-acid metabolism (Metabolic disease) 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 > 3.5 µg/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.

Email Form

Coordinator LookUp