

Guidelines for Completing the *Children 1st* Screening and Referral Form #3267 Revised 3-18-02

Over the last several years, the impact of parenting, stimulation and environment on brain development in the early years of life and on long-term child development has been well established. For these reasons, Children 1st looks at the broad array of biological and socio-environmental risk factors affecting the well being of a child and family. Children 1st provides a population-based system of screening young children for specific risk conditions which place the child at risk for adverse health and/or developmental outcomes.

Some Health Districts identify at-risk children by accessing State Vital Records birth data files, while others rely on external referrals for identification of births. Both referral sources may be utilized within a health district. The Children 1st Screening and Referral Form is a standardized form used to identify and screen children who need further assessment and follow-up after the period of birth and up to the fifth birthday. In addition, Children 1st helps to simplify the process of referral to public health programs by being the **single point of entry** for families to connect with public health programs and prevention based programs and services.

Once identified, each birth is screened for risk status. Children can be identified as having **Level 1** and/or **Level 2** conditions. **Level 1** risk conditions involve socio-environmental risks as well as certain medical/biological conditions present in the child. **Level 2** risk conditions represent a group of children needing specific medical services and referral to public and/or private sector care agencies. In some situations, children can be identified as having both socio-environmental and medical risks making them both **Level 1** and **Level 2**.

The Children 1st Screening and Referral form can be completed by any person who has a concern regarding a child's health and/or development. The referral source should complete as much as possible. Completed Children 1st Screening and Referral forms are sent to the **Children 1st District Coordinator** for processing and follow-up.

Section A: Child and Family Information

Name of Child	Enter last name on birth certificate, first name, and middle initial.
Name of Mother	Enter last name, first name, middle initial and maiden name.
Name of Father	Enter last name, first name, and middle initial.

Child's Information

Child's Address	Enter street address of child. Include zip code and county of residence.
Phone #	List home phone number with area code.

Emergency Contact #	List cellular or pager number of parent, neighbor, relative or friend where family can be reached in emergency; including area codes.
Directions to Home	Include directions to child's home.
Latino/Hispanic	Circle yes or no to indicate if child is of Latino or Hispanic descent, based on parent report.
Select one or more race	Circle all that apply, based on parent report.
Sex of Child	Circle if child is male, female or sex is unknown.
DOB	Indicate month, date and year of birth.
Birthweight	Indicate child's birth weight.
Gestational Age	Indicate number of weeks gestation at time of birth.
Birth Hospital	Indicate name of hospital of delivery.
Date of Discharge	Indicate date child was discharged from hospital of delivery.
Transfer Hospital	Indicate name of hospital child was transferred to after delivery, if applicable.
Date of Discharge	Indicate date child was discharged from transfer hospital.
Type of Insurance	Circle type of insurance coverage for child.
Medicaid #	List child's Medicaid number if known.
<u>Language Needs</u>	
Language	List the primary language spoken by mother.
Translator Needed	Circle yes or no to indicate if a translator or interpreter is needed for family.
<u>Mother's Information</u>	
Age	Indicate age of mother at time of referral.
DOB	Indicate month, date and year of birth.
Education	Indicate highest level of education completed.
Marital Status	Circle marital status. M – Married, NM – Never Married, SEP – Married but Separated, D – Divorced and not remarried, W- Widowed and not remarried.
Live in Partner	Circle yes or no to indicate if mother is living with partner.

Parity **G/Gravida** -Indicate number of pregnancies.
P/Para - Indicate number of live births.
Pre-Term - Indicate number of pre-term births.
AB: E/S -Indicate number of **E - Elective** abortions and the number of **S - Spontaneous** abortions.

Prenatal Care Circle trimester (**1st 2nd or 3rd**) mother began to receive prenatal care for this pregnancy. If mother did not receive any prenatal care, circle **none**.

Medicaid # List Medicaid number if known.

Guardian/Foster Parent

Name of Guardian List name of Guardian, if different from above information about mother. Use **Section G, Comments**, to list primary language spoken by guardian and if a translator is needed.

Child's Primary Medical/Health Care Provider

Primary Care Provider Information Indicate name of primary care provider, address, phone and fax number. Include area codes.

Section B: Hospital Information

Newborn Hearing Screening Circle **Not Screened** if newborn did not receive a hearing screening before hospital discharge. Circle **Family Refused Screening** if family chose not to have newborn screened. Indicate date of screening. Circle **pass** or **refer** result for each ear (L = Left, R = Right) of the **outpatient** and/or **inpatient** screening(s). Circle the type of equipment used for the screening: **AOAE, AABR** or **Other**.

Vaccines Given During Hospital Stay Indicate the date of administration of Hepatitis B Vaccine and/or Hepatitis B Immune Globulin provided to child.

Section C: Level 1 Risk Conditions (Families Offered In-Home Assessment)

Conditions Identified at Birth

Circle **XXX.11 (Negative Family Index)**, if maternal age is less than 20, maternal education is less than 12 years and there is no father's name on birth certificate (**All three risk conditions must exist in order to circle Negative Family Index; however, any one of these risk conditions indicate a need for an in-home family assessment.**)

Circle **XXX.13 (Negative Healthy Start Index)**, if infant's birth weight is less than 2500 grams (5 lbs. 8 ozs.), there was no 1st trimester care, and mother smoked and/or drank during pregnancy - drank greater than 7 drinks per week. (**All three risk conditions must exist in**

order to circle Negative Healthy Start Index; however, any one of these risk conditions indicate a need for an in-home family assessment.)

Circle **XXX.14**, if two or more of the following six risk conditions are present:

(Maternal age less than 20 years, maternal education less than 12 years, no father's name on the birth certificate, infant's birth weight less than 2500 grams [5 lbs. 8ozs.], no 1st trimester prenatal care, mother smoked and or drank during pregnancy.)

Note: If XXX.11, XXX.13, XXX.14 are circled, a home assessment is indicated.

Medical/Biological Conditions Present in the Child. (Any 1)

Special Care Nursery > 48 hours (specify medical conditions on back), Small for Gestational Age (birth weight \leq 10% for gestational age), HIV+ by EI, WB or PCR, Drug Withdrawal Syndrome in Newborn.

Socio-Environmental Conditions Present in the Family (Any 1)

Family History of Hearing Impairment, Multiparity in Mother <20 Years (> 3 pregnancies), Previous or Current Child in Protective Services/Foster Care, History of Family Violence, Difficulty Parenting due to Lack of Family/Social Support, Questionable Mother/Child Attachment, Abortion Sought or Attempted this Pregnancy, Maternal Substance Abuse, Homelessness, Maternal Mental Illness, Especially Depression, Maternal Mental Retardation, Maternal Physical Illness or Disability Affecting Care of Child, Inadequate Material Resources Affecting Care of Child, Parental Incarceration, Three or more injuries in 1 Year Requiring Medical Attention, Other Maternal Conditions Significantly Affecting Care of Child (please specify on line provided).

Section D: Signatures

Name of Person Completing Form	Indicate first/last name and title of person completing the form.
Agency	Indicate referring agency of person completing form.
Phone	Indicate phone number of person completing form.
Date	Indicate date form is completed.
Parent's Signature	If parent is present, signature representing consent for referral is encouraged, but not required.
Parent Informed of referral	Circle yes or no to indicate if parent been informed of referral.

Section E: Level 2 Risk Conditions

**Medical/Biological Conditions Present in Child
Indicating Referral to Public or Private Sector Care**

Circle **ALL** that apply under each category: **Conditions Identified in Newborn Period, Congenital Infections (Documented), Acquired Infections (Documented), Clinical Evidence of CNS Abnormality/Disorder, Genetic Conditions, Serious Problems or**

Abnormalities of Body Systems and/or **Other Significant Conditions**. Specify conditions not listed, as appropriate.

Section F: Referral Criteria Legend

Children 1st Coordinator or designated Public Health staff should use the legend as a guide to make appropriate referrals to public health programs. The referral programs include: **HRIFU** - High Risk Infant Follow-up, **CMS** - Children's Medical Services, **BCW** - Babies Can't Wait, **Genetics, Lead Program**. Those children identified as being at risk for hearing loss should be tracked and monitored as appropriate through Children 1st. Referrals to other programs and services should be made as needed.

Section G: Comments

Note any pertinent information about family or child that would assist the Children 1st Coordinator in supporting the family.

Section H: For Health Department Use Only (complete only by Public Health Staff)

Date Form Received	Indicate date public health staff received referral.
Source of Referral	Circle only one referral source. Indicate any other referral source not listed.
Date Assessment Completed	Indicate date Children 1 st in-home family assessment was completed.
Referrals Resulting From Assessment	Circle yes or no to specify whether or not referral was made as a result of Children 1 st in-home family assessment.
Date of Referral Directly to PH Programs (Level 2 only)	Date of referral into public health programs for Level 2 children only.
Reason for Discharge (Circle only1)	Cannot Locate, Unresponsive, Moved Out of State, Moved Out of Care, Pending in (list date) Active in (list) Inappropriate Referral, Consent Withdrawn/Refused Date (list date) or Out of Service Age Group (list date)

Ordering Additional Forms

Additional forms may be obtained by contacting the **Children 1st District Coordinator**. A list of district coordinators can be obtained by calling (800) 822-2539. The **Children 1st Screening and Referral** form may also be downloaded from the Children 1st website: <http://health.state.ga.us/programs/childrenfirst/>

3/18/02 rev