

PURPOSE: To identify and refer children to the Child Service Coordination Program and to collect information on their risk conditions.

PREPARATION: Hospital – This form is to be completed by hospital personnel or public health nurses assigned responsibility for identifying and referring children to the Child Service Coordination Program. Items that are shaded are to be completed by the health department in the county where the child resides.

Post-Discharge – This form is to be completed by the professional who refers the child to the Child Service Coordination Program. Items that are shaded are to be completed by the health department in the county where the child resides.

DISTRIBUTION: COMPLETED IDENTIFICATION AND REFERRAL forms are forwarded to the health department in the county where the child resides.

INSTRUCTIONS: Numbers correspond to item numbers on the front of this form.

1. **Patient's Name:** Enter last name, first name and middle initial.
2. **Patient Number:** Enter the child's HSIS or temporary identification number. To be entered by the health department in the county where the child resides.
3. **Date of Birth:** Enter the child's eight-digit date of birth, e.g., May 1, 1993 = .
4. **Race:** Enter the code number that corresponds to the child's race, e.g., black = . If there is no appropriate code for child's race, enter code for mother's race.
5. **Ethnicity:** Enter the code that indicates whether the primary culture of the child's home/family is Hispanic, e.g., Yes = .
6. **Special Populations:** Respond Y or N to all items in the left column. Country of origin requires: 1=Mexico, 2=Haiti or 9=All others including USA.
7. **Sex:** Enter the code number that corresponds to the child's sex, e.g., male = .
8. **County of Residence:** Write in the name of the county where the child's family resides. The health department in the county of residence enters the three-character code for the county of residence. Refer to Child Service Coordination Program Manual.
9. **Child has Medicaid, Other Insurance, Self-Pay, or Medicare:** Respond Y or N to each category.
10. **Designated Service Coordination Agency:** Enter name of agency. Health department confirms designation and enters agency code.
11. **Information and Referral Completion Date:** Referral source enters the date the form was completed using the six-digit date, e.g. May 1, 1993 = .
12. **Referral Source:** Print the name, agency, address, and telephone number of the person referring the child to the Child Service Coordination Program.
13. **Parental Information:** Enter the name, telephone number, address, and directions to home.
14. **Information and Referral Receipt Date:** The health department enters the date the completed Information and Referral form is received using the six-digit date, e.g. May 1, 1993 = .
15. **Risk Conditions:** Circle the code number of each risk condition identified. Refer to Child Service Coordination Manual for definitions.
16. **Child's Primary Medical Provider:** Enter name, address, and telephone number of child's primary medical provider, if known.
17. **Referrals:** Check all referrals requested by the family and made at this time or check no referrals block. Each service is defined in Bulletin No. 15 of the Infant-Toddler Program Manual.
18. **Parent has been informed about Child Service Coordination:** Check appropriate response.

DISPOSITION: This form may be destroyed in accordance with the Programs Operational Records Standard of the *Records Disposition Schedule* published by the North Carolina Division of Archives and History.

REORDER

INFORMATION: Additional copies may be ordered on the REQUISITION FOR CHILDREN AND YOUTH MATERIALS (DHHS 3526) from:

N.C. Department of Health and Human Services
Division of Public Health/Women's and Children's Services Section
Children and Youth Branch
1916 Mail Service Center
Raleigh, NC 27699-1916