YOLO COUNTY CHILDREN'S ALLIANCE
& CHILD ABUSE PREVENTION COUNCIL
www.yolokids.org

**Step by Step/Paso a Paso: Record Screen**

Mother's Name _____ Birthdate _____
Address _____ Zip Code _____ Phone # _____
Hospital _____ F.O.B. Name _____
F.O.B. Birthdate _____
Mother's email address: _____
EDD (Expected due date) _____
Baby's name _____ D.O. B. _____ M/F Weight _____
Does family have other children? O Yes If yes, how many? _____
O NO

**Referral source name and agency: Phone number**

**Referral Response Requested? ☐ YES ☐ NO**

**Answer each of the following statements with T (true), F (false) or U (unknown).**

_____1. Marital status: Single, Separated, Divorced (*circle one*)
_____2. Partner unemployed
_____3. Inadequate income or no information regarding source of income
_____4. No permanent housing
_____5. No phone
_____6. No high school diploma or GED
_____7. Inadequate emergency contacts
_____8. History of substance abuse
_____9. Late prenatal, poor compliance
_____10. History of pregnancies/miscarriage
_____11. History of psychiatric care
_____12. Unsuccessful or terminated pregnancies
_____13. Relinquishment for adoption sought or attempted
_____14. Marital or family problems
_____15. History of or current mental health issues

**Health Insurance** *(circle one)*
MediCal
Other _____

**Language** *(circle one)*
English
Spanish
Other _____

**Ethnicity Categories** (*circle one*)
American Indian/Alaskan Native
Asian/Pacific Islander
Hispanic/Latino
White – not Hispanic Origin
African American – not Hispanic Origin
Other/mixed: _____

**NOTES:**
_____
_____
_____

**Others reasons for referral:**
O CPS Involvement
O Parent Support
O Teen Pregnancy
O Basic Needs
O Child Development Education
O Special Need _____
O Self-harming behavior
O Individual/Family Counseling

**Referral has been discussed with family ☐**
Form Completed by (Name & Title) _____ Date: _____

**Please FAX completed form to: 530-753-7662**