DECISION TREE REFERRAL GUIDE (Original Screener)

THE HEALTH OF YOU AND YOUR BABY IS IMPORTANT TO US…

INFANT (0 TO 1 YEAR)

Taking a few minutes now to answer these questions will help us provide you with the care and services you and your baby need. Please remember, everything that affects you affects your baby. All information on this form will be kept confidential.

Date_____

Infant's Name_____ Birth Date_____

Your Name_____ Relationship to Infant_____

1. Do you or your partner have any problems/concerns with breast feeding?	Share Breastfdg Resource list
2. Are you currently using birth control?	**Family Planning**
3. Do you have someone who could take care of your baby if you need a break?	**Social Support**
4. Who can you count on when you need help?	**Social Support**
5. How often do you read, talk, or play with your baby?	**Parenting/Social Support**
6. Do you have any concerns about you and your baby bonding?	**Parenting/Social Support**
7. How often is your baby held during bottle feeding?	**Parenting/Social Support**
8. Do you have any concerns about your baby's development or behavior?	**Parenting/Social Support**
9. How would you discipline your child? (Mark all that apply)	**Parenting/Social Support**
10. Have you ever been afraid you or your partner might lose control and hurt your baby?	**Parenting/Social Support**
11. Are there areas in your home that could be dangerous for your baby, such as stairways, water (temperature or drowning), electrical, lead, poisons, fire, pets?	
12. Do you always put your baby in a rear facing car seat?	Refer to Safe Kids Coalition if need a car seat – 391-7233
13. Does your baby always sleep alone, on his/her back, in a crib or bassinette?	

14. How many times have you moved in the last year?	**Basic Needs: Housing**
15. Do you feel that you live in a safe place?	
16. How do you rate your current stress level? **Additional screening tool- Perceived Stress Scale	**Mental Health/ Social Support/ Parenting**
17. During the last two weeks have you felt unhappy, sad, or hopeless? **Additional screening tool- Edinburgh Postnatal Depression Scale	**Mental Health/ Social Support**
18. During the last two weeks, have you had little interest or pleasure in doing things you used to enjoy? **Additional screening tool- Edinburgh Postnatal Depression Scale	**Mental Health/ Social Support**
19. Do you or anyone in your family have a history of nerves, depression, or other mental health issues? **Additional screening tool- Edinburgh Postnatal Depression Scale	**Mental Health/ Social Support**
20. In the past year, has anyone pushed, punched, kicked, hit, or threatened to hurt you?	**Domestic Violence**
21. While you were pregnant, did you use any tobacco, alcohol, or street drugs, including marijuana?	**Substance Abuse**
22. Do you or anyone in your household currently smoke?	**Substance Abuse**
23. Does anyone in your household use alcohol?	**Substance Abuse**
24. How much beer/liquor/wine/wine coolers do you drink?	**Substance Abuse**
25. Do you or anyone in your household use any street drugs, including marijuana?	**Substance Abuse**
26. Do you have any difficulties reading or understanding materials given to you by your medical provider?	
27. Do you have any trouble meeting your basic needs such as transportation, food, clothing, housing, child care?	**Basic Needs:Food/ BN:Housing/BN:Utility/ Transportation: Medical/ Non-Medical**
28. Are there any faith, spiritual, or cultural practices that may affect the medical care of your infant?	

29. I would like more information about_____

_____

Thank you!

Healthy Kent 2010
Infant Health Team

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