DECISION TREE REFERRAL GUIDE (Clinic 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_______________

#	Question	Referral
1.	Do you or your partner have any problems/concerns with breast feeding?	Share Breastfeeding Resource List
2.	Are you having sex without using birth control?	**Family Planning**
3.	Do you or your partner have any questions/concerns about your options for birth control?	**Family Planning**
4.	Is it difficult to find someone you count on when you need help or need a break?	**Social Support**
5.	Is it difficult to take time to read, talk, or play with your baby daily?	**Parenting/Social Support**
6.	Do you have any concerns about you and your baby bonding?	**Parenting/Social Support**
7.	When feeding your baby do you prop the bottle?	**Parenting/Social Support**
8.	Do you have any concerns about your baby's development or behavior?	**Parenting/Social Support**
9.	Have you ever thought of spanking your baby?	**Parenting/Social Support**
10.	Have you ever been afraid you or your partner might lose control and hurt your baby or children?	**Parenting/Social Support**
11.	Are there areas in your home that could be dangerous for your baby/children, such as stairways, water (temperature or drowning), electrical, lead, poisons, fire, pets?	
12.	Does your baby ever ride in a car without being in a rear facing car seat?	Refer to Safe Kids Coalition if need car seat- 391-7233
13.	Does your baby sleep anywhere besides alone, in a crib, on his back?	
14.	Have you moved more than once in the last year?	**Basic Needs:Housing**
15.	Do you ever feel that where you live is unsafe?	
16.	Do you feel as though you are currently under a lot of stress? ** 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 your partner 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.	Does anyone in your household currently smoke?	**Substance Abuse**
23.	Do you or your partner drink more than 7 drinks (beer/liquor/wine/wine coolers) per week?	**Substance Abuse**
24.	Do you or anyone in your household use any street drugs, including marijuana?	**Substance Abuse**
25.	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**
26.	Do you have any difficulties reading or understanding materials given to you by your medical provider?	
27.	Are there any faith, spiritual, or cultural practices that may affect the medical care of your baby?	
28.	Have you previously been screened and referred for any of the concerns above?	

28. I would like more information about______________________________

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Thank you!

Healthy Kent 2010
Infant Health Team

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