

South Los Angeles Best Babies Collaborative Case Management Client Screening and Referral Form

Date of Screening: _____ Screened by: _____

Client Information:	Preferred Language: _____
Full Name: _____	DOB (mm/dd/yy): _____
Address: _____	
City: _____	Zip: _____
Phone #: _____	Alt Tel. #: _____
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Not currently pregnant

Check appropriate client characteristics for the purpose of determining whether the client is eligible for referral to SLABBC Case Management services. Please check all that apply.
To be eligible for participation, clients must meet **age, income, and risk factor** criteria.

Client Characteristics

Client Age

- Female of childbearing age (12 – 45 years)

Client Income

- Income less than 300 % of the federal poverty level

Client Risk Factors

- Teenager (12-19 years)
- Current hypertension or a history of pregnancy related hypertension (self-reported)
- Diabetes (gestational, Type 1, Type 2) or a history of gestational diabetes (self-reported)
- Other chronic disease that may impact the outcome of a future pregnancy
(Please specify): _____
- Substance Abuse: (current, within the past 6 months, or any use during a past pregnancy)
____ Tobacco
____ Alcohol
____ Street Drugs
____ Over-the-Counter Medication
- Previous poor pregnancy outcome (preterm, low birth weight, or infant death)

SLABBC Referral:

If at least one criterion under “Client Age”, “Client Income”, and “Client Risk Factors” is checked, the client may be eligible for case management services. Refer the client to the appropriate case manager. Indicate below the name of the agency and the Case Manager to whom the client was referred to for initiation of SLABBC services. Please keep a copy of this form on file.

Agency: _____

Case Manager: _____ Date: _____

SLABBC Enrollment:

- Client meets criteria for enrollment: Yes No • Client signed informed consent form: Yes No
- If the client is an unemancipated minor: Parent signed informed consent form: Yes No NA

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