PARENT-CHILD ASSISTANCE PROGRAM

COMMUNITY REFERRAL SCREENING QUESTIONNAIRE (CRSQ)

Date of Referral:

A. REFERRAL SOURCE
Name/Position: Phone:
Agency: (*include area code*)
Address:
(include zip code)

B. CLIENT INFORMATION
Name: Phone:
Address: (*include area code*)
(include zip code)

How to contact:

Demographics: Birthdate: Age:
Race: # of children *(incl. Target Child whether or not born):*

Has the referent asked the mother if she is willing to be contacted by a PCAP staff member? ☐ Yes ☐ No
If yes, a PCAP staff member may contact the client, using the script below.

Has the referent asked the client to call PCAP? ☐ Yes ☐ No

ELIGIBILITY FOR PCAP ENROLLMENT *[Client must meet all 3 following conditions to be enrolled in PCAP]*

1. PREGNANCY STATUS

Currently Pregnant
Estimated Gestational Age (GA): Due Date: Planned Hospital of Delivery:

Postpartum
Date of Delivery: Hospital of Delivery:

• **CURRENTLY PREGNANT OR UP TO 12 MONTHS POSTPARTUM** .... *No, ineligible* .... ***Yes***
(or up to 24 months postpartum if there's space available)

2. SELF-REPORT OF HEAVY ALCOHOL OR DRUG USE DURING THIS PREGNANCY

Alcohol? Approximate amount/frequency:

Drugs? Describe type and patterns of use:

Includes Opioid medication for opioid use disorder

Other indicators of use during this pregnancy:
(e.g., any mom or baby positive toxicology screen(s) during this pregnancy?)

• **USED ALCOHOL OR DRUGS HEAVILY DURING THIS PREGNANCY?** .... *No, Ineligible* .... ***Yes***

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3. INVOLVEMENT WITH COMMUNITY SERVICES DURING PREGNANCY

Any Alcohol/Drug Treatment now or during pregnancy? *(describe)*:

Involved With Other Services

- ☐ Any advocacy/case management programs?
- ☐ Any home visitation programs?
- ☐ AA, NA/other treatment support group?
- ☐ Mental health services?
- ☐ Other supportive group/church?
- ☐ Regular family doctor, OB/GYN?
- ☐ Public health nurse?
- ☐ CPS?
- ☐ Public housing?
- ☐ Legal services?
- ☐ Domestic violence services?
- ☐ Other program

If connected to services, but only ineffectively, how so?

• NOT EFFECTIVELY CONNECTED WITH COMMUNITY SERVICES? .... *No, effectively connected, ineligible* .... ***Yes, not effectively connected***

OTHER NOTES/CONTACTS MADE: *(Include date and notes about all contact phone calls, texts, etc. made and outcome. If referral is not eligible for enrollment, or eligible but not enrolled, explain briefly. Use additional pages if necessary.)*