Imperial County
Home Visiting Program an Affiliate of Healthy Families America*
Screening Tool

This information will be shared with the California Home Visiting Program (California Department of Public Health) and Imperial County Home Visiting Program. By initialing below, I agree to share this information with both organizations.
***Initials Here*** _____

**Mother's Contact Information** Screening Date: ____/____/_____ (mm/dd/yyyy)
First Name: _____ Last Name: _____
Street Address: _____
City: (circle one) El Centro Holtville Imperial Seeley Heber Zip Code: _____
Home Phone: (____)____ - _____ Work Phone: (____ )_____ - _____ Cell Phone: (___)_____-_____
Best phone number to contact: (____)____-_____ Best time of day to contact: _____ a.m. _____ p.m.
Email: _____Date of Birth: ____/____/_____ (mm/dd/yyyy)

**Screening Information**
Screening Site ID:_____ Screener Name:_____

*Time of screening (check one):*
Prenatal: ☐ First Trimester ☐ Second Trimester ☐ Third Trimester Expected Date of Delivery (EDD)____/____/_____

Postnatal: ☐ Within two weeks after birth ☐ More than two weeks after birth

Method of screening: (please check) ☐ Administered to expectant/new parent

**Referral Information**

*Referred to screening site by: (check one)*
☐ Child Protective Services ☐ Community Based Organization ☐ Family or Friend ☐ Head Start
☐ Hospital ☐ HFA client ☐ Other HFA program ☐ Physician office or clinic
☐ Self-referred ☐ School ☐ WIC ☐ Other: _____
Name of referral organization/program: _____

**Risk Factors**

| | | | |
|---|---|---|---|
| 1. Marital status is single, separated, divorced or widowed | ☐ True | ☐ False | ☐ Unknown |
| 2. Husband/partner unemployed | ☐ True | ☐ False | ☐ Unknown |
| 3. Inadequate income | ☐ True | ☐False | ☐ Unknown |
| 4. Unstable housing | ☐ True | ☐ False | ☐ Unknown |
| 5. No phone | ☐ True | ☐ False | ☐ Unknown |
| 6. Education under 12 years | ☐ True | ☐ False | ☐ Unknown |
| 7. Inadequate emergency contacts | ☐ True | ☐ False | ☐ Unknown |
| 8. History of substance abuse | ☐ True | ☐ False | ☐ Unknown |
| 9. Late or no pre-natal care, poor compliance | ☐ True | ☐ False | ☐ Unknown |
| 10. History of abortions | ☐ True | ☐ False | ☐ Unknown |
| 11. History of psychiatric care | ☐ True | ☐ False | ☐ Unknown |
| 12. Abortion unsuccessfully sought or attempted | ☐ True | ☐ False | ☐ Unknown |
| 13. Relinquishment for adoption sought or attempted | ☐ True | ☐ False | ☐ Unknown |

14. Marital or family stresses ☐ True ☐ False ☐ Unknown
15. History of or current depression ☐ True ☐ False ☐ Unknown

**Outcome** *

Screening outcome (check one): ☐ Positive ☐ Negative

If positive, was referral made to Imperial County Home Visiting Program

Family Assessment Worker - Yolanda Bernal (check one): ☐ Yes ☐ No

If referral was not made, indicate reason why (check one):

☐Screened Negative ☐ No time available to participate ☐ Refused/not interested
☐ Other_____

***Submit completed screening tool to ICHVP within 48 hrs. (via confidential fax (760) 482-4460, hand delivery to 935 Broadway, El Centro, CA 92231, or call to pick up (760 )482-4917).**

NOTES: _____
_____
_____
_____
_____

**For ICHVP Use Only**

FAW Name: _____
Date Referral Received: _____ Date Client Contacted: _____
Appointment Date for Parent Survey (Kempe Assessment): _____

Outcome of Parent Survey (Kempe Assessment): ☐ Positive ☐ Negative
Enrollment Date: _____
Dismissal Date: _____

Reason for Dismissal (check one):
☐ Negative Screen
☐ Miscarriage/abortion/adoption or deceased index child
☐ Language barrier
☐ Moving/moved out of service area
☐ Unable to locate/contact
☐ Participating in another program
☐ Program full
☐ Other_____