

Healthy Babies Healthy Children Referral

ML MIDDLESEX-LONDON
HEALTH UNIT
www.healthunit.com
FAX: 519-663-8243



Name (Parent or Mother): _____
Address: _____
Postal Code: _____
Telephone No.: () _____ - _____
D.O.B (Mother or Parent) _____

Appendix A to Report No. 008-20

Health Connection use only:
Self-Referral NOC discussed
PHN Initials _____

Referred by:
Name: _____ Agency: _____
Phone: _____ - _____ - _____

TO BE SIGNED BY PARENT:

Healthy Babies Healthy Children (HBHC) is a voluntary program to support all expectant mothers and families from childbirth to the transition to school. I will ask you a series of questions about your pregnancy, birth, parenting, and your family history. This information will be sent to your local health unit so that a Public Health Nurse can contact you.

I want to participate in the Healthy Babies Healthy Children Program and I understand that a copy of the personal information on this form will be shared with my local health unit.

Client Signature _____ Date: _____

CHILD:
DOB: _____ Name: _____
Gestation: wks _____ Birth Wt: _____ gms Sex: M F Delivery: Vaginal C-Section

MOTHER:
Marital Status: S M Common-law GTPAL: _____ EDB: _____
Mother's Maiden Name: _____ Partner's name: _____
Family Physician: _____ Language: English Other: _____

REASON FOR REFERRAL:

<input type="checkbox"/> Prenatal Support	<input type="checkbox"/> Infant Feeding	<input type="checkbox"/> Child Behaviour
<input type="checkbox"/> Growth & Development	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Safety
<input type="checkbox"/> Perinatal Mood Disorder (PPD)	<input type="checkbox"/> Infant / Child Health	<input type="checkbox"/> Other _____

Notes:

Name (Parent or Mother): _____

Reason for no response:

A requires further assessment, B client declined to answer, C unable to assess

Section A: Pregnancy & Birth

	Yes/No	Reason for no response
1) Multiple birth?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*2) Premature? (born at less than 37 weeks gestation)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*3) Was the birth weight less than 1500g?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*4) Was the birth weight more than 4000g?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*5) Apgar score of less than 5 at five minutes?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
6) Health conditions/medical complications during pregnancy that impact infant? <i>eg. diabetes</i>	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> <i>Please List :</i>
*7) Complications during labour and delivery? (e.g. scheduled caesarean, emergency caesarean, infant trauma or illness such as respiratory distress syndrome, difficult vaginal birth including forceps or vacuum)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> <i>Please List :</i>
8) Maternal smoking of cigarettes during pregnancy?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
9) Maternal smoking of more than 100 cigarettes (5 packs) in her lifetime prior to pregnancy?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
10) Maternal alcohol use during pregnancy?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
11) Maternal drug use during pregnancy? (include information on illegal drug use and prescription drugs that impact on activities of daily living or are teratogenic)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> <i>Please List :</i>
12) No prenatal care before sixth month?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>

Section B: Family

Mother		
13) Is less than 18 years old?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
14) Was less than 18 years old when first child was born?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
15) Experienced a previous loss? (pregnancy or baby)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
16) Is a single parent?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
17) Mother and child do NOT have a designated primary care provider?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
18) Does NOT have an OHIP number?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
19) Did NOT complete high school?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
Infant/Child		
20) Congenital or Acquired Health Challenge?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
<i>Please List:</i>		
*21) Maternal separation from infant greater than 5 days?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
<i>Please specify reason:</i>		
Partner/Father/Support Person		
22) Father/partner/support person is NOT involved with care of baby?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>

Section C: Parenting

	Yes/No	Reason for no response
23) Client cannot identify support person to assist with parenting of the baby/child?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
24) Client cannot identify support person to assist with care of the baby/child?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
25) Client or family in need of newcomer support?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
26) Client has concerns about money to pay for housing/rent and family's food, clothing, utilities and other basic necessities?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
27) Client or parenting partner has a history of depression, anxiety, or other mental illness?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
28) Client or parenting partner has a disability that may impact parenting?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
29) Client expresses concern about their ability to parent child/baby?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
30) Client expresses concern about their ability to care for baby/child?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
31) Client's relationship with parenting partner is strained? (evidence of relationship stress observed)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
32) Client or parenting partner has been involved with Child Protection Services as a parent?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*33) Client expresses that his/her child is difficult to manage?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
*34) Client's response patterns are inconsistent or inappropriate to the baby's child's cues? (evidence of inappropriate responses observed)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>

Section D: Infant/Child Development

*35) Parent(s) identified a risk factor? (e.g., hearing, speech and language, communication skills, social development, emotional development behaviour, motor skills, vision, cognitive development, self help skills)	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
---	---	--

Section E: Health Care Professional Observations

36) Health care professional has concerns about the wellbeing of client and/or baby?	Y <input type="checkbox"/> N <input type="checkbox"/>	A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
--	---	--

Additional Comments:

Signature(s) of health care professional(s) completing Screen with client:

Date: _____

Please print name: _____

Professional Title: RN RPN NP Midwife MD Other _____

Regular Screening of Families

Health care providers are in a unique position to have an impact on positive childhood development outcomes by virtue of their ongoing contact with patients and families over time. Completed screens need to be sent to your local public health department's Healthy Babies Healthy Children Program so that families can receive the supports and services needed. This screen is intended to identify with risk families who may benefit from the Healthy Babies Healthy Children home-visiting program during the prenatal, postnatal or early childhood periods.

Instructions for Completion

Please provide ONE response for each question: If a yes/no response cannot be provided, please indicate the reason for no response in the right-hand column. Reason for no response: **A.** individual completing the screen may have concerns or suspect a risk but needs more information in order to confidently identify this item as a risk. **B.** indicates that the client declined to answer the question. **C.** unable to assess or unable to ask the client (for example, client was in distress, there was no opportunity for a private discussion about the risk, etc.).

For all questions, a "Yes" indicates a risk. Some items have been reversed, questions 17, 18, 19 and 22, so that a "yes" indicates a risk. For example, "Mother does NOT have an OHIP number". The more "yes" responses, the more likely a family is at risk.

This HBHC Screen should be used for prenatal, postnatal and early childhood clients:

Screening of prenatal clients:

- Conception to birth of infant.
- Answer all questions except for questions 2, 3, 4, 5, 7, 21, 33, 34, 35 (marked with an asterisk). These questions DO NOT apply when screening prenatal clients and should be left BLANK.

Screening of postnatal clients:

- Birth up to 6 weeks of age. In the case of multiple births, one screen is completed for each infant.
- Answer all questions.

Screening of early childhood clients

- From 6 weeks of age. One screen is completed for each infant/child.
- Answer all questions.

Suggested Introduction to Screening for Health Care Professionals

"As part of the Healthy Babies Healthy Children program, all families in Ontario are offered the chance to speak to someone about how they are doing (during their pregnancy, after the birth of a baby, or when their children are in early childhood).

I would like to spend some time talking to you about your family, the supports you have, and any challenges that you may face. We gather the same kind of information from all families at this stage (pregnancy, after birth, early childhood of children) and use the information to support families in getting services that they may find helpful.

If you find there are some things you don't feel comfortable talking to me about, just let me know and we will move to another topic. If you have any questions or concerns throughout our discussion today, please let me know. If you and your family might need some extra support. A Public Health Nurse will contact you to talk about services that may be available to you."

Additional Information for Selected Questions

All questions are grounded in evidence and are reflective of the identification of potential risk. References are available upon request.

The following provides additional tips for completing specific questions.

Section A: Pregnancy and Birth (Questions 1-12)

- 5) Please complete even if scores are provided.
- 6) Health conditions/medical complications during pregnancy that **impact** infant.
Include: diabetes, eclampsia, congenital herpes, rubella, HIV, Hepatitis B, abruptio placenta.
- 7) Complications during labour and delivery.
Include: labour that required mid forceps, including breech delivery or emergency caesarean due to complications. Infant trauma or distress including respiratory distress syndrome and convulsions.
- 9) Evidence demonstrates that 100 cigarettes is the threshold for establishing Nicotine addiction.
- 10) Ask every mother about her alcohol use throughout her pregnancy. Discussing alcohol use and fetal development with all women normalizes discussion of this issue and introduces a harm reduction approach to prevention.
- 11) Maternal drug use during pregnancy
Include: illegal drug use during pregnancy and prescription drugs that impact on activities of daily living or are teratogenic. Exclude: non-teratogenic prescription drugs and small amounts of over-the-counter drugs.

Section B: Family (Questions 13-22)

- 15) Include previous loss at any stage of pregnancy and at any age, includes loss of a twin, stillbirth, miscarriage, and abortion due to complications.
- 16) Include if mother identifies herself as sole primary caregiver for child (include unmarried, separated, widowed, divorced and common-law relationship less than one year).
- 20) Include confirmed congenital or acquired health challenge with probability of permanent disability (e.g. vision or hearing impairment, Down's Syndrome, birth asphyxia, etc.). If a suspected health challenge exists then "A" should be checked off.
- 21) Include mothers sent home from hospital while baby is still hospitalized (applies to postnatal period).
- 22) Question refers to the person that the mother identifies as the secondary caregiver to her current child and can include biological father, boyfriend, her mother, friend.

Section C: Parenting (questions 23-34)

- 23 & 24) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).
- 25) A mother who is new to Canada, less than 5 years living in Canada, who lacks social supports, or is experiencing social isolation (newcomer is defined as someone new to Canada).
- 27) Include present or past depression, anxiety or emotional problems. Include if either mother OR father/parenting partner indicates a history of mental illness.
- 28) Include mental or physical challenge for mother OR father/parenting partner.
- 29 & 30) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).
- 31) Include distress or conflict between parenting partners (e.g. separation, frequent arguments, presence of physical, verbal, emotional or sexual abuse in the home). This could be broadly defined as either by direct observation or expressed by the client.

Note: Screening questions related to partner violence should not be asked with partner present with client.
- 32) Include family's past or present involvement with Child Protection Services. Exclude involvement of client or parenting partner with Child Protection Services when they were a child.
- 33) Consider client's perception of difficulty managing the baby/child's behavior (eg. Temper tantrums, excessive crying, biting, etc.)
- 34) Include inappropriate or lack of response when baby/child is in need of comfort, lack of eye contact or physical contact. This could be broadly defined as either by direct observation or expressed by the client.

Section D: Infant/Child Development (Question 35)

- 35) This question should be answered in direct response to a developmental concern specifically raised by the parent and should not include parent concerns or questions about the normal care of a newborn or child. Areas of development include vision, hearing and communication, gross and fine motor, cognitive, social/emotional, and self-help. Parental concerns may be identified through the Nipissing Developmental District Screening TM (NDDS) tool that assists parents and caregivers to monitor child development. More information on the NDDS can be found at www.ndds.ca

Section E: Health Care Professional Observations (Question 36)

- 36) Health care professional's concern(s) includes professional observations of the client and family.

Consent:

The check box for consent refers to verification by the health care provider that the necessary consent has been obtained (as described in PHIPA). Client consent refers to both consent to disclose personal information and personal health information, and consent to participate in the HBHC Program. If client declines further participation in the HBHC Program, cross out participation only.

Signature:

The screen should be signed by the individual who obtains consent from the mother and completes the Screen. If additional information is completed by another practitioner, this individual should provide their initial and signature with designation on the Screen, and initial the responses collected.