DIRECTIONS: Please complete form on every child, birth to age 5, having any of the conditions listed on 1st or 2nd page. Circle or fill in as much information as possible. Send form to local *Children 1st* Coordinator.

Screening and Referral Form

SECTION A — CHILD AND FAMILY INFORMATION

Child: Last Name First MI

Mother: Last Name First MI Maiden

Father: Last Name First MI

CHILD'S INFORMATION

Child's Address ______________________________
Street/Route Apt Complex # / Mobile Hm Park #
____
City County Zip

Phone # ______________ **Emergency Contact #** ________________

Directions to Home ______________________________
____

Latino/Hispanic: Y/N/UNK

Select one race: (1) White (2) Black or African American (3) American Indian or Alaska Native (4) Asian (5) Hawaiian or Other Pacific Islander (6) Multiracial (7) Unknown

Sex: Male Female Unknown Date of Birth ______________
Birth weight____________________ **Gestational Age**____________

Hospital ____________________ **Discharge Date** ________________
Transfer Hospital ____________ **Discharge Date** ________________

Type of Insurance: Private Tri-Care PeachCare Medicaid None/Unknown

Medicaid # (if known)______________________

MOTHER'S INFORMATION

Age____________ **Date of Birth**________________________

Education (last grade completed) ________________________

Marital Status ***(circle only 1)*****: M NM SEP D W**
Live in Partner: Y/N

Parity G:____ **P:**____ **Pre-Term:**____ **AB: Elective/Spontaneous** ___/___

Prenatal Care 1st 2nd 3rd None

Medicaid #__________________

GUARDIAN/FOSTER PARENT (If different from above)

____
Last Name First MI

CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER

____
Name
____
Street or Route
____
City State Zip
________________ ________________
Phone Fax

LANGUAGE NEEDS

Primary Language:________________Translator/Interpreter Needed: Y/N

SECTION B — HOSPITAL INFORMATION

Newborn Hearing Screening: **Not screened** **Family Refused Screening**
Inpatient: Date: ___/___/___ L: Passed/Referred R:Passed/Referred **Equipment**: AOAE AABR Other
Outpatient: Date: ___/___/___ L: Passed/Referred R:Passed/Referred **Equipment**: AOAE AABR Other

Vaccines Given During Hospital Stay:
Hepatitis B Vaccine (date) ___________
HBIG (date) ____________

SECTION C — LEVEL 1 RISK CONDITIONS
(Circle all that apply) **(Families Offered In-Home Assessment)**

Conditions Identified at Birth

XXX.11 ***Negative Family Index (includes XXX.12, V62.3 & V62.9)***
- XXX.12 Maternal Age <20 years
- V62.3 Maternal Education <12 Years
- V62.9 No Father's Name on Birth Certificate

XXX.13 ***Negative Healthy Start Index (765, V23.7, & XXX.17)***
- 765 Birth weight <2500 Grams (5 lbs. 8 oz.)
- V23.7 No 1st Trimester Prenatal Care
- XXX.17 Mother Smoked and/or Drank (> 7 drinks/week) during Pregnancy

XXX.14 ***2 or More of the 6 Risk Conditions Listed Above***

Medical/Biological Conditions Present in the Child (Any 1)

- XXX.15 Special Care Nursery >48 hours (specify medical conditions on back)
- 764.9 Small for Gestational Age (birth weight ≤ 10% for gestational age)
- 795.8 HIV+ by EI, WB or PCR
- 779.5 Drug Withdrawal Syndrome in Newborn

Socio-Environmental Conditions Present in the Family (Any 1)

- V19.2 Family History of Hearing Impairment
- V61.5 Multiparty in Mother <20 Years (more than 3 pregnancies)
- V61.21 Previous or Current Child Protective Services/Foster Care
- V61.8 History of Family Violence
- V62.89 Difficulty Parenting Due to Lack of Family/Social Support
- V61.20 Questionable Mother/Child Attachment
- V61.7 Abortion Sought or Attempted this Pregnancy
- V61.4 Maternal Substance Abuse (alcohol, street, prescription or OTC drugs as documented by self-report, drug screen or court record)
- V60.0 Homelessness
- V17.0 Maternal Mental Illness, Especially Depression
- V18.4 Maternal Mental Retardation
- V16-V19 Maternal Physical Illness or Disability Affecting Care of Child
- V60.2 Inadequate Material Resources Affecting Care of Child
- V62.5 Parental Incarceration
- XXX.16 Three or More Injuries in 1 Year Requiring Medical Attention
- XXX.06 Other Maternal Conditions Significantly Affecting Care of Child
  Specify ______________________________

SECTION D — SIGNATURES

Name of Person Completing Form | Agency | Phone | Date

Parent Signature (encouraged but not required for referral) | Parent Informed of Referral? Yes/No

Child's Name:	**Mother's Name:**

SECTION E **LEVEL 2 RISK CONDITIONS**

(Circle all that apply) **(Medical/Biological Conditions Present in Child Indicating Referral to Public or Private Sector Care)**

Conditions Identified in Newborn Period

Symbols	Code	Condition
● 👂	765.0	Birth weight ≤1000gms (2lbs. 3oz.)
● 👂	765.14-765.15	Birth weight ≤ 1500 Grams (3lbs. 5oz.) and > 1000gms
●	770.9	Significant Respiratory Distress (vent. > 48hrs)
● 👂	768.5	Apgar ≤ 3 at 5 Minutes (asphyxia)
● ☐	772.1	Intraventricular Hemorrhage (IVH) Grade III or IV
● ☐	434.9	Periventricular Leukomalacia (PVL)
● 👂	774.6	Hyperbilirubinemia Requiring Exchange Transfusion
●	777.5	Necrotizing Enterocolitis Requiring Surgery
● ❖	770.7	Bronchopulmonary Dysplasia
●	779.0	Seizures in Newborn
●	770.8	Apnea
●	362.21	Retinopathy of Prematurity
●	767	Injury During Perinatal Period

Serious Problems or Abnormalities of Body Systems

Symbols	Code	Condition
● ❖ ☐ 👂	749	Cleft Palate/Lip
● ❖	750-751	Digestive System
● ❖	752-753	Genito-Urinary System
● ❖	745-747	Heart/Circulatory System
● 👂	744	Head, Ear and Neck
● ❖	756	Musculoskeletal System
● ❖	748	Respiratory System
❖	493	Asthma
● ❖	759	Other Congenital Abnormalities

Specify Conditions for All Above

____

____

Congenital Infections (Documented)

Symbols	Code	Condition
● ☐ 👂	771.1	Cytomegalovirus
●	774.4	Hepatitis B (Infant)
●	V02.6	Hepatitis B (Mother)
● ☐ 👂	771.2	Herpes
● ☐ 👂	771.0	Rubella
● ☐ 👂	090	Syphilis
● ☐ 👂	771.2X	Toxoplasmosis

Acquired Infections (Documented)

Symbols	Code	Condition
● 👂	323.9	Encephalitis
● ☐ 👂	320	Meningitis, Bacterial
● 👂	321	Meningitis, All Other

Clinical Evidence of CNS Abnormality/Disorder

Symbols	Code	Condition
●	779.9	Abnormal Reflexes/Motor Functioning
● ❖ ☐	343	Cerebral Palsy
● ☐	740	Anencephalus
● ❖ ☐	742.3	Hydrocephalus
● ❖ ☐	742.1	Microcephalus
● ❖ ☐	741	Spina Bifida/Myelomeningocele
● ☐	348.3	Encephalopathy
❖ ☐	345	Seizure Disorder/Epilepsy

Other Significant Conditions

Symbols	Code	Condition
● ☐	760.71	Fetal Alcohol Syndrome
●	783.4	Failure to Thrive/Growth Deficiency (Growth below 5th %)
❖ ☐ 👂	389.9	Hearing Impairment
❖ ☐ 👂	389.9X	Suspected Hearing Impairment
❖ ☐	369.9	Visual Impairment
❖	369.9X	Suspected Visual Impairment
☐	299.0	Autism
❖ ☐	358-359	Neuromuscular Disorder
●	779.3	Significant Feeding Problems/ Reflux/Feeding Tubes
☐	315.9	Developmental Delay
☐	315.9X	Suspected Developmental Delay
☐	315.3	Speech/Language Delay
♥ ❖	984	Lead Level ≥ 20ug/dl (Venous) Specify_________________
♥	984.X	Lead Level ≥ 10 <20 ug/dl (Venous) Specify__________________
👂	960.6 –960.8	Ototoxic medications
👂	854.00	Head Trauma
👂	382.9	Recurrent or persistent otitis media
👂	237.72	Neurofibromatosis Type II and neurodegeneration disorders
● ❖	XXX.03	Other Medical Condition(s) Affecting Child Specify_______________________________________

____

Genetic Conditions

Symbols	Code	Condition
❖ ☐ ✖	758.0	Down Syndrome
❖ ☐	758	Major Chromosomal Abnormal Specify_____________
❖ ☐ ✖	XXX.07	Metabolic Disease Specify___________________
❖ ✖	282	Hemoglobinopathy Specify ___________________

SECTION F **REFERRAL CRITERIA LEGEND**

Symbols indicate conditions addressed by the programs below. The *Children 1st* Coordinator/appropriate staff should make referrals.

● High Risk Infant Follow-Up if <1 year	✖ Genetics
❖ Children's Medical Services	♥ Lead Program
☐ Babies Can't Wait if <3 years	👂 Track/Monitor for Hearing Loss

SECTION G **COMMENTS**

SECTION H **FOR HEALTH DEPARTMENT USE ONLY**

Date Form Received __________

Source of Referral (*circle only 1*):

Birth Certificate	Head Start	School
Hospital	Pre-K	Daycare Center
Physician	Parent	Public Health
DFCS	UNHS	Other ____________

SSI (Supplemental Security Income)

Date Assessment Completed: ______

Referrals Resulting from Assessment

Yes No

Date of Referral Directly to PH Programs

(*Level 2 only*): ____________

Reason for Discharge (***circle only 1***)**:**

Cannot Locate	Unresponsive
Pending in________	Moved out of State
Active in _________	Moved out of Care

Inappropriate Referral

Consent Withdrawn/Refused Date: ________________

Out of Service Age Group

Guidelines for Completing the *Children 1st* Screening and Referral Form #3267 Revised 3-18-02

Over the last several years, the impact of parenting, stimulation and environment on brain development in the early years of life and on long-term child development has been well established. For these reasons, Children 1st looks at the broad array of biological and socio-envrionmental risk factors affecting the well being of a child and family. Children 1st provides a population-based system of screening young children for specific risk conditions which place the child at risk for adverse health and/or developmental outcomes.

Some Health Districts identify at-risk children by accessing State Vital Records birth data files, while others rely on external referrals for identification of births. Both referral sources may be utilized within a health district. The Children 1st Screening and Referral Form is a standardized form used to identify and screen children who need further assessment and follow-up after the period of birth and up to the fifth birthday. In addition, Children 1st helps to simplify the process of referral to public health programs by being the ***single point of entry*** for families to connect with public health programs and prevention based programs and services.

Once identified, each birth is screened for risk status. Children can be identified as having ***Level 1*** and/or ***Level 2*** conditions. ***Level 1*** risk conditions involve socio-environmental risks as well as certain medical/biological conditions present in the child. ***Level 2*** risk conditions represent a group of children needing specific medical services and referral to public and/or private sector care agencies. In some situations, children can be identified as having both socio-environmental and medical risks making them both **Level 1** and **Level 2**.

The Children 1st Screening and Referral form can be completed by any person who has a concern regarding a child's health and/or development. The referral source should complete as much as possible. Completed Children 1st Screening and Referral forms are sent to the **Children 1st District Coordinator** for processing and follow-up.

Section A: Child and Family Information

Name of Child — Enter last name on birth certificate, first name, and middle initial.

Name of Mother — Enter last name, first name, middle initial and maiden name.

Name of Father — Enter last name, first name, and middle initial.

<u>Child's Information</u>

Child's Address — Enter street address of child. Include zip code and county of residence.

Phone # — List home phone number with area code.

Emergency Contact #	List cellular or pager number of parent, neighbor, relative or friend where family can be reached in emergency; including area codes.
Directions to Home	Include directions to child's home.
Latino/Hispanic	Circle **yes** or **no** to indicate if child is of Latino or Hispanic descent, based on parent report.
Select one or more race	Circle all that apply, based on parent report.
Sex of Child	Circle if child is male, female or sex is unknown.
DOB	Indicate month, date and year of birth.
Birthweight	Indicate child's birth weight.
Gestational Age	Indicate number of weeks gestation at time of birth.
Birth Hospital	Indicate name of hospital of delivery.
Date of Discharge	Indicate date child was discharged from hospital of delivery.
Transfer Hospital	Indicate name of hospital child was transferred to after delivery, if applicable.
Date of Discharge	Indicate date child was discharged from transfer hospital.
Type of Insurance	Circle type of insurance coverage for child.
Medicaid #	List child's Medicaid number if known.

<u>Language Needs</u>

Language	List the primary language spoken by mother.
Translator Needed	Circle **yes** or **no** to indicate if a translator or interpreter is needed for family.

<u>Mother's Information</u>

Age	Indicate age of mother at time of referral.
DOB	Indicate month, date and year of birth.
Education	Indicate highest level of education completed.
Marital Status	Circle marital status. M – Married, NM – Never Married, SEP – Married but Separated, D – Divorced and not remarried, W-Widowed and not remarried.
Live in Partner	Circle **yes** or **no** to indicate if mother is living with partner.

Parity	**G/Gravida** -Indicate number of pregnancies. **P/Para** - Indicate number of live births. **Pre-Term -** Indicate number of pre-term births. **AB: E/S** -Indicate number of **E** - **Elective** abortions and the number of **S** - **Spontaneous** abortions.
Prenatal Care	Circle trimester (**1st 2nd** or **3rd**) mother began to receive prenatal care for this pregnancy. If mother did not receive any prenatal care, circle **none**.
Medicaid #	List Medicaid number if known.

Guardian/Foster Parent

Name of Guardian	List name of Guardian, if different from above information about mother. Use **Section G**, **Comments**, to list primary language spoken by guardian and if a translator is needed.

Child's Primary Medical/Health Care Provider

Primary Care Provider Information	Indicate name of primary care provider, address, phone and fax number. Include area codes.

Section B: Hospital Information

Newborn Hearing Screening	Circle ***Not Screened*** if newborn did not receive a hearing screening before hospital discharge. Circle ***Family Refused Screening*** if family chose not to have newborn screened. Indicate date of screening. Circle ***pass*** or ***refer*** result for each ear (L = Left, R = Right) of the ***outpatient*** and/or ***inpatient*** screening(s). Circle the type of equipment used for the screening: **AOAE**, **AABR** or **Other**.
Vaccines Given During Hospital Stay	Indicate the date of administration of Hepatitis B Vaccine and/or Hepatitis B Immune Globulin provided to child.

Section C: Level 1 Risk Conditions (Families Offered In-Home Assessment)

Conditions Identified at Birth

Circle **XXX.11** (**Negative Family Index**), if maternal age is less than 20, maternal education is less than 12 years **and** there is no father's name on birth certificate (**All three risk conditions must exist in order to circle Negative Family Index; however, any one of these risk conditions indicate a need for an in-home family assessment.**)

Circle **XXX.13** (**Negative Healthy Start Index**), if infant's birth weight is less than 2500 grams (5 lbs. 8 ozs.), there was no 1st trimester care, **and** mother smoked and/or drank during pregnancy - drank greater than 7 drinks per week. **(All three risk conditions must exist in**

order to circle Negative Healthy Start Index; however, any one of these risk conditions indicate a need for an in-home family assessment.)
Circle **XXX.14,** if two or more of the following six risk conditions are present:
(Maternal age less than 20 years, maternal education less than 12 years, no father's name on the birth certificate, infant's birth weight less than 2500 grams [5 lbs. 8ozs.], no 1st trimester prenatal care, mother smoked and or drank during pregnancy.)

<u>Note</u>: **<u>If XXX.11, XXX.13, XXX.14 are circled, a home assessment is indicated.</u>**

Medical/Biological Conditions Present in the Child. (Any 1)

Special Care Nursery > 48 hours (specify medical conditions on back), Small for Gestational Age (birth weight ≤ 10% for gestational age), HIV+ by EI, WB or PCR, Drug Withdrawal Syndrome in Newborn.

Socio-Environmental Conditions Present in the Family (Any 1)

Family History of Hearing Impairment, Multiparity in Mother <20 Years (> 3 pregnancies), Previous or Current Child in Protective Services/Foster Care, History of Family Violence, Difficulty Parenting due to Lack of Family/Social Support, Questionable Mother/Child Attachment, Abortion Sought or Attempted this Pregnancy, Maternal Substance Abuse, Homelessness, Maternal Mental Illness, Especially Depression, Maternal Mental Retardation, Maternal Physical Illness or Disability Affecting Care of Child, Inadequate Material Resources Affecting Care of Child, Parental Incarceration, Three or more injuries in 1 Year Requiring Medical Attention, Other Maternal Conditions Significantly Affecting Care of Child (please specify on line provided).

Section D: Signatures

Name of Person Completing Form	Indicate first/last name and title of person completing the form.
Agency	Indicate referring agency of person completing form.
Phone	Indicate phone number of person completing form.
Date	Indicate date form is completed.
Parent's Signature	If parent is present, signature representing consent for referral is encouraged, but not required.
Parent Informed of referral	Circle **yes** or **no** to indicate if parent been informed of referral.

Section E: Level 2 Risk Conditions

Medical/Biological Conditions Present in Child
Indicating Referral to Public or Private Sector Care

Circle **ALL** that apply under each category: **Conditions Identified in Newborn Period**, **Congenital Infections (Documented)**, **Acquired Infections (Documented)**, **Clinical Evidence of CNS Abnormality/Disorder**, **Genetic Conditions**, **Serious Problems or**

Abnormalities of Body Systems and/or **Other Significant Conditions**. Specify conditions not listed, as appropriate.

Section F: Referral Criteria Legend

Children 1st Coordinator or designated Public Health staff should use the legend as a guide to make appropriate referrals to public health programs. The referral programs include: **HRIFU -** High Risk Infant Follow-up, **CMS** - Children's Medical Services, **BCW** - Babies Can't Wait, **Genetics**, **Lead Program**. Those children identified as being at risk for hearing loss should be tracked and monitored as appropriate through Children 1st. Referrals to other programs and services should be made as needed.

Section G: Comments

Note any pertinent information about family or child that would assist the Children 1st Coordinator in supporting the family.

Section H: For Health Department Use Only (complete only by Public Health Staff)

Date Form Received — Indicate date public health staff received referral.

Source of Referral — Circle only one referral source. Indicate any other referral source not listed.

Date Assessment Completed — Indicate date Children 1st in-home family assessment was completed.

Referrals Resulting From Assessment — Circle **yes** or **no** to specify whether or not referral was made as a result of Children 1st in-home family assessment.

Date of Referral Directly to PH Programs *(Level 2 only)* — Date of referral into public health programs for Level 2 children only.

Reason for Discharge *(Circle only1)* — **Cannot Locate**, **Unresponsive**, **Moved Out of State**, **Moved Out of Care**, **Pending in** (list date) **Active in** (list) **Inappropriate Referral**, **Consent Withdrawn/Refused Date** (list date) or **Out of Service Age Group** (list date)

Ordering Additional Forms

Additional forms may be obtained by contacting the **Children 1st District Coordinator**. A list of district coordinators can be obtained by calling (800) 822-2539. The **Children 1st Screening and Referral** form may also be downloaded from the Children 1st website: http://health.state.ga.us/programs/childrenfirst/

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DISTRICT COORDINATORS

DISTRICT	CHILDREN 1ST COORDINATOR	PHONE/FAX/E-MAIL	COUNTIES SERVED	
1-1 **ROME** Northwest Health District	**Jamie Youngblood** 1309 Redmond Rd, NW Rome, GA 30165	706.802.5626 706.802.5309 FAX jmyoungblood@dhr.state.ga.us	Bartow Catoosa Chattooga Dade Floyd	Gordon Haralson Paulding Polk Walker
1-2 **DALTON** North Georgia Health District	**Sheri Faix** 100 West Walnut Avenue Suite 92 Dalton, GA 30720	888.276.1558 Toll Free 706.272.2219 FAX 706.272.2266 svfaix@dhr.state.ga.us	Cherokee Fannin Gilmer	Murray Pickens Whitfield
2 **GAINESVILLE** North Health District	**Tonya Newsom** 1856 Thompson Bridge Road Suite103 Gainesville, GA 30501	770.538.2778 FAX 770.538.2784 tenewsom@dhr.state.ga.us	Banks Dawson Forsyth Franklin Habersham Hall Hart	Lumpkin Rabun Stephens Towns Union White
3-1 **COBB/DOUGLAS** Health District	**Laurie A. Ross** 1650 County Services Parkway Marietta, GA 30008	770.514.2460 FAX770.514.2742 Pager: 404.742.5788 laross@dhr.state.ga.us	Cobb	Douglas
3-2 **FULTON** Health District	**Margaret Gamble** 1225 Capital Ave SE Atlanta, GA 30315	404.612.4077 FAX 404.893.6516 margaret.gamble@fultoncountyga.gov	Fulton	
3-3 **CLAYTON** Health District	**Tori M. Cheney** 1117 Battlecreek Rd. Jonesboro, Ga. 30236	678.610.7365 FAX 770. 603.4174 tmcheney@dhr.state.ga.us	Clayton	

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DISTRICT	CHILDREN 1ST COORDINATOR	PHONE/FAX/E-MAIL	COUNTIES SERVED
3-4 **GWINNETT** East Metro Health District	**Deborah Chosewood** P.O. Box 897 Lawrenceville, GA 30046-0897	770-339-5372 FAX 770-963-1418 Referral Line 770-339-5048 dcchosewood@dhr.state.ga.us.	Gwinnett Rockdale Newton
3-5 **DEKALB** Health District	**Aletha Dixon** DeKalb County Board of Health 440 Winn Way Decatur, GA 30031	404.294.3814 FAX 404.294.6316 ardixon@dhr.state.ga.us	DeKalb
4 **LAGRANGE** Health District	**Phyllis Turner** 122 Gordon Commercial Drive Suite A LaGrange, GA 30240	706.845.4035 FAX 706.845.4351 pturner@dhr.state.ga.us	Butts Carroll Coweta Fayette Heard Henry Lamar Meriwether Pike Spalding Troup Upson
5-1 **DUBLIN** South Central Health District	**Kerrie Fountain** 2121 B Bellevue Road Dublin, GA 31021	478.275.6841 FAX 478.274.7893 kyfountain@dhr.state.ga.us	Bleckley Dodge Johnson Laurens Montgomery Pulaski Telfair Treutlen Wheeler Wilcox
5-2 **MACON** North Central Health District	**Deborah Clark** 811 Hemlock Street Macon, GA 31201	478.751.6179 FAX 478.751.6429 dmclark@dhr.state.ga.us	Baldwin Bibb Crawford Hancock Houston Jasper Jones Monroe Peach Putnam Twiggs Washington Wilkinson

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DISTRICT	CHILDREN 1ST COORDINATOR	PHONE/FAX/E-MAIL	COUNTIES SERVED	
6 **AUGUSTA** East Central Health District	**Susan Edmunds** 1916 North Leg Road Augusta, GA 30909	706.667.4757 FAX 706.667.4555 sjedmunds@dhr.state.ga.us	Burke Columbia Emanuel Glascock Jefferson Jenkins Lincoln	McDuffie Richmond Screven Taliaferro Warren Wilkes
7 **COLUMBUS** West Central Health District	**Lori Hirsch** 705 17th Street Suite 207 Columbus, GA 31902	706.327.0951 FAX 706.327.9288 llhirsch@dhr.state.ga.us	Chattahoochee Clay Crisp Dooly Harris Macon Marion Muscogee	Quitman Randolph Schley Stewart Sumter Talbot Taylor Webster
8-1 **VALDOSTA** South Health District	**Lisa Thomas** 206 S. Patterson Street 3rd Floor P.O. Box 1027 Valdosta, GA 31603	800.316.8044 Toll Free 229.293.6286 FAX 229.293.6292 ajthomas@dhr.state.ga.us	Ben Hill Berrien Brooks Cook Echols	Irwin Lanier Lowndes Tift Turner
8-2 **ALBANY** Southwest Health District	**Sherry Holman** 1306 South Slappy Boulevard Suite A - Colony Square South Albany, GA 31701	800.430.4212 Toll Free 229.430.4310 FAX 229.430.1379 syholman1@dhr.state.ga.us	Baker Calhoun Colquitt Decatur Dougherty Early Grady	Lee Miller Mitchell Seminole Terrell Thomas Worth

DISTRICT	CHILDREN 1ST COORDINATOR	PHONE/FAX/E-MAIL	COUNTIES SERVED	
9-1 **COASTAL** Coastal Health District	**Jackie King** 132 Stephenson Avenue Suite 100 Savannah, GA 31405	866.647.0010 Toll Free 912.691.6882 FAX 912.351.3493 jmking@dhr.state.ga.us	Effingham Bryan Camden Chatham	Glynn Liberty Long McIntosh
9-2 **WAYCROSS** Southeast Health District	**Wanda Bennett** 1115 Church Street Suite A Waycross, GA 31501	912.287.4843 FAX 912.338.5914 wbbennett@dhr.state.ga.us	Appling Atkinson Bacon Brantley Bulloch Candler Charlton Clinch	Coffee Evans Jeff Davis Pierce Tattnall Toombs Ware Wayne
10 **ATHENS** Northeast Health District	**Robin O'Donnell** 220 Research Drive Athens, GA 30605	706.227.7182 FAX 706.227.7184 rjodonnell@dhr.state.ga.us	Barrow Clarke Elbert Greene Jackson	Madison Morgan Oconee Oglethorpe Walton

If you need further information, please contact:

Patrice Harris – Children's 1st Program Nurse Consultant
2 Peachtree Street, NW, Suite 11-457, Atlanta, GA 30303
pdharris@dhr.state.ga.us

or

CCHS Administrative Operations Coordinator
2 Peachtree Street, NW, Suite 11-458, Atlanta, GA 30303

Website: http://health.state.ga.us/programs/childrenfirst/

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