Parent-Child Assistance Program

OMB # 0930- XXXX

Expiration Date: xx/xx/xxxx

COMMUNITY REFERRAL SCREENING QUESTIONNAIRE (CRSQ)

County: Michigan Department of Community Health- Network 180 Michigan Department of Community Health- Lakeshore Coordinating Council

Southern California Alcohol and Drug Programs Other: ________________________________

Client ID:______________

Recruitment script read

Recruitment script for initial researcher contact with eligible mothers:

"INSERT RECRUITMENT SCRIPT TEXT HERE"

REFERRAL SOURCE

Name/Position: Phone:

Agency:

Address:
(include zip code)

Date of Referral: __ __/__ __/__ __ __ __
Mo Day Year

CLIENT INFORMATION

Name: Phone:

Address:
(include zip code)

How to contact:

Date of Screening: __ __/__ __/__ __ __ __
Mo Day Year

Demographics: Client DOB _______________ PIC# ___________

Age _____ Race _____________ # of Children *(incl.Target Child whether or not born)* ______

Marital Status _________________________ Highest Grade Completed in School _______

Native Language ________________ Speaks English? ___ US citizen or documented?_____

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx. Public reporting burden for this collection of information is estimated to average 5 minutes per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland,20857.

Community Referral Screening Questionnaire, pg 2

Last Name: ___________________

Date Screened: ___________________

ELIGIBILITY FOR ENROLLMENT *[Client must meet currently pregnant or within 6 months postpartum condition and alcohol condition to be enrolled in PCAP]*

1. **PREGNANCY STATUS:** Is client currently pregnant? [If yes go to Currently Pregnant section, if no go to Postpartum section]

Currently Pregnant

Estimated Gestational Age (GA): ______ weeks   Due Date:

Planned Hospital of Delivery:

ENROLLEES EARLY IN PREGNANCY MUST HAVE MULTIPLE INDICATORS OF HIGH-RISK.

Circle all that apply: Alcohol/drug abuse, Previous exposed pregnancy,
Previous children removed, Tx failures, Other:___________________________________

Postpartum

Date of Delivery: Hospital of Delivery:

Complications:

• **CURRENTLY PREGNANT OR WITHIN 6 MONTHS POSTPARTUM**........................ *No, ineligible* .... ***Yes***
(EARLY PREGNANCY WITH HIGH-RISK INDICATIONS)

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

Alcohol/Drug(s) of choice:

History of Problem (esp. during this pregnancy):

Name/Type of Drug:

Amount:

Frequency (circle one):   Daily   Weekly   Monthly

Positive Toxicology Screen(s):

Mother: Baby:

• **USED ALCOHOL DURING THIS PREGNANCY?** .... *No, ineligible* .... ***Yes***

* ANY Alcohol use reported

3. **INVOLVEMENT WITH COMMUNITY SERVICES DURING PREGNANCY**

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

Other Services:

AA, NA/other treatment support group?

Mental health services?

AIDS/HIV 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?

Last Name: ____________________

Date Screened: ____________________

Prenatal Care:

Where (name of clinic/physician):

G.A. at start: ______ weeks

Approx. # visits:

Any unusual factors in prenatal care? (e.g., prenatal care in jail, high-risk pregnancy?)

With which advocacy/case management-type programs is this woman already connected?
(Names, description of involvement)

• **NOT EFFECTIVELY CONNECTED WITH COMMUNITY SERVICES?** .... *Effectively connected, Ineligible* .... ***Yes, not effectively connected***

OTHER NOTES/CONTACTS MADE: *(include reason if referral is not eligible for enrollment, or eligible but not enrolled)*