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?____

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 (EARLY PREGNANCY WITH HIGH-RISK INDICATIONS) ..... *No,* ..... ***Yes*** *ineligible*

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,* ..... ***Yes*** *ineligible*

* 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)*