

## Child Health and Disability Prevention Program Care Coordination / Follow-up Form

<b>Patient Name</b> (Last) _____ (First) _____ (Initial) _____			<b>Language</b> _____		<b>Date of Service</b> Month _____ Day _____ Year _____	
<b>Birthdate</b> Month _____ Day _____ Year _____		<b>Age</b> _____	<b>Sex</b> _____	<b>Gender</b> _____	<b>Patient's County of Residence</b> _____	<b>Telephone #</b> (Home or Cell) ( _____ ) _____
<b>Responsible Person</b> (Name) _____ (Street) _____ (Apt/Space #) _____ (City) _____ (Zip) _____					<b>Alternate Phone #</b> (Work or Other) ( _____ ) _____	
<b>Patient Eligibility</b>		<b>County</b> _____	<b>Aid Code</b> _____	<b>Identification Number</b> _____	<b>Next CHDP Exam Date</b> Month _____ Day _____ Year _____	
Is the patient a Medi-Cal Managed Care Plan enrollee? <input type="checkbox"/> Yes <input type="checkbox"/> No						
						<b>Ethnic Code</b> <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Hispanic/Latino <input type="checkbox"/> 3. Black/African American <input type="checkbox"/> 4. American Indian/Alaska Native <input type="checkbox"/> 5. Asian <input type="checkbox"/> 6. Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 7. Other

### A. Medical Assessment and Referral Section

<input type="checkbox"/> <b>No Medical Problems Suspected</b>		<b>Significant Medical History or Special Conditions:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify: _____	
Physical Exam	Problem Suspected	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	<b>Comments:</b>
	Problem Suspected	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	
Developmental Screening	<input type="checkbox"/> Speech Delay <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Cognitive <input type="checkbox"/> Fine Motor Delay <input type="checkbox"/> Gross Motor Delay <input type="checkbox"/> Other	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	
Vision Screening	<input type="checkbox"/> Problem Suspected <input type="checkbox"/> Not screened – rescheduling <input type="checkbox"/> Other: _____	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	
Hearing Screening	<input type="checkbox"/> Problem Suspected <input type="checkbox"/> Not screened – rescheduling <input type="checkbox"/> Other: _____	Referred To & Contact # Or <input type="checkbox"/> Return Visit Scheduled	

### B. Dental Assessment and Referral Section

<input type="checkbox"/> <b>Class I:</b> No Visible Problems  Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)	<input type="checkbox"/> <b>Class II:</b> Visible decay, small carious lesion or gingivitis  Needs non-urgent dental care	<input type="checkbox"/> <b>Class III: Urgent</b> – pain, abscess, large carious lesions or extensive gingivitis  Immediate treatment for urgent dental condition which can progress rapidly	<input type="checkbox"/> <b>Class IV: Emergent</b> – acute injury, oral infection or other pain  Needs immediate dental treatment within 24 hours
<b>Fluoride Varnish Applied:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, parent refused <input type="checkbox"/> No, teeth have not erupted <input type="checkbox"/> Other reason for not applying: _____			
<input type="checkbox"/> <b>Dental home referral</b>		<b>Referred To and Contact Number:</b> _____	

### C. Referring Provider Information

<b>Service Location:</b> Office Name, Address, Telephone and Fax Number  _____ _____ _____	<b>Provider Office NPI Number</b>
	<b>Rendering Provider Name</b> (Print Name)
	<b>Provider Signature</b>
	<b>Date</b>