

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

Patient Name (Last) _____ (First) _____ (Initial) _____			Language _____		Date of Service Month _____ Day _____ Year _____	
Birthdate Month _____ Day _____ Year _____		Age _____	Sex _____	Gender _____	Patient's County of Residence _____	Telephone # (Home or Cell) (_____) _____
Responsible Person (Name) _____ (Street) _____ (Apt/Space #) _____ (City) _____ (Zip) _____					Alternate Phone # (Work or Other) (_____) _____	
Patient Eligibility					Ethnic Code	
County _____		Aid Code _____	Identification Number _____		Next CHDP Exam Date: Month _____ Day _____ Year _____	
					<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"/> No Medical Problems Suspected		Significant Medical History or Special Conditions: <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify: _____	
Physical Exam	Problem Suspected	Referred To & Contact # _____ Or <input type="checkbox"/> Return Visit Scheduled	Comments:
	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"/> Class I: No Visible Problems Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)	<input type="checkbox"/> Class II: Visible decay, small carious lesion or gingivitis Needs non-urgent dental care	<input type="checkbox"/> Class III: Urgent – pain, abscess, large carious lesions or extensive gingivitis Immediate treatment for urgent dental condition which can progress rapidly	<input type="checkbox"/> Class IV: Emergent – acute injury, oral infection or other pain Needs immediate dental treatment within 24 hours
Fluoride Varnish Applied: <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"/> Dental home referral		Referred To and Contact Number: _____	

C. Referring Provider Information

Service Location: Office Name, Address, Telephone Number	Provider Office NPI Number
	Rendering Provider Name (Print Name)
	Provider Signature
	Date