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

Patient Name	(Last)			(First)					(Initial)	Langu	Language			Date of Service Month Day Year
Birthda Month Day	a te Year	Age	Sex	Gender	Patient's C	County of Reside	ence	Tele (phone #(Home o	r Cell)	-	Alterna (te Phone # (Work or Other)
Responsible Pe		Name) Aid Code	e Iden	(Street)	(Apt/Space #)		(Cit	y) Next CHDI Month	P Exam	(Zip) Date: Year	Ethi	nic de 3.	White Hispanic/Latino Black/African American American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander
A. Medical	Assa	seman	and	Referral Section	\n								7.	. Other
□ No Medical				Significant Medica or Special Conditi	al History	□No □ Yes, Specify: _								
	Problem Suspected				R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled	Com	ments	:
Physical Exam	Problem Suspected				R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled			
	Problem Suspected				R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled			
Nutritional Assessment	Probler	n Suspec	ted		R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled			
Developmental Screening		•		ocial/Emotional Gross Motor Delay	□ Other	eferred To & Con					Scheduled			
Vision Screening	□ Prob	•	ected	☐ Not screened – res	scheduling R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled			
Hearing Screening	□ Prob		ected	□ Not screened – res	scheduling R	eferred To & Con	itact #	Or	□Retur	n Visit S	Scheduled			
B. Dental A	Sses	sment	and R	eferral Section	1									
☐ Class I: No Vi					•				Urgent – pain, abscess, large sions or extensive gingivitis					IV: Emergent – acute oral infection or other pain
referral (begins age 1 and reco	ning no l	no later than		Needs non-urge dental care	nt				treatment for urgent dental which can progress rapidly			Needs immediate dental treatment within 24 hours		
Fluoride Varnisl	h Applie			☐ No, parent refusason for not applying		No, teeth have no	t erupt	ted						
□ Dental home	referral		ferred ⁻ ntact N	Го and umber:										
C. Referrin	g Pro	vider Ir	nform	ation										
Service Location: Office Name, Address, Telephone Number								Provider Office NPI Number						
								Rendering Provider Name (Print Name)						
								Provider Signature						
							D	ate						