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)	**Alternate Phone #** (Work or Other)
					( )	( )

Responsible Person (Name) (Street) (Apt/Space #) (City) (Zip)

Patient Eligibility	County	Aid	Identification Number	**Next CHDP Exam Date**: (Month, Date, Year)

Health Coverage: ☐Medi-Cal FFS ☐Gateway ☐Managed Care Plan

Ethnic Code ☐

1. American Indian
2. Asian
3. Black
4. Filipino
5. Mex.Amer./Hispanic
6. White
7. Pacific Islander
8. Other

A. Medical Assessment and Referral Section

☐**No Medical Problems Suspected**

Significant Medical History or Special Conditions: ☐No ☐ Yes, Specify: ____________________

			Comments:
Physical Exam	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
Developmental Screening	☐Speech Delay ☐Social/Emotional ☐Cognitive ☐Fine Motor Delay ☐Gross Motor Delay ☐Other	Referred To & Contact # Or ☐Return Visit Scheduled	
Vision Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other: ____________________	Referred To & Contact # Or ☐Return Visit Scheduled	
Hearing Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other: ____________________	Referred To & Contact # Or ☐Return Visit Scheduled	

B. Dental Assessment and Referral Section

☐**Class I:** No Visible Problems	☐**Class II:** Visible decay, small carious lesion or gingivitis	☐**Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis	☐**Class IV: Emergent** – acute injury, oral infection or other pain
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)	Needs non-urgent dental care	Immediate treatment for urgent dental condition which can progress rapidly	Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: ____________________

☐**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

Revised 07/2017