Child Health and Disability Prevention Program

Care Coordination / Follow-up Form

Submit to the County CHDP Program within 5 business days of the examination - eFax: (831) 763-8410 ATTN: CHDP

Do not complete this form if child is in the foster care system. Health Care providers are required to submit a HCPCFC Foster Care Medical (Specialty)/ Dental Contact Form for all types of appointments. For foster children - providers only complete page 2.

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 Code	Identification Number	**Next CHDP Exam Date**: Month Day Year

Ethnic Code ☐

1. White
2. Hispanic/Latino
3. Black/African American
4. American Indian/Alaska Native
5. Asian
6. Native Hawaiian/Other Pacific Islander
7. Other

A. Medical Assessment and Referral Section

☐ **No Medical Problems Suspected**

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

Physical Exam	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	**Comments:**
	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

Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis

Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis

Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain

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 09/2017