

STANDARD VISIT (SV) FORM



NAME: _____ (Last, First) **HRIF I.D. #** _____

**Required Field*

***Date of Visit:** - - (MM-DD-YYYY)

VISIT ASSESSMENT

***Core Visit (1)** #1 (4-8 months) #2 (12-16 months) #3 (18-36 months)

Infant enrolled in a CCS clinic other than the HRIF Program: No Yes Unknown

Zip Code of Primary Caregiver:

Chronological Age: Months Days **Adjusted Age:** Months Days

Interpreter Used

No

Yes:

<input type="checkbox"/> Spanish	<input type="checkbox"/> Arabic	<input type="checkbox"/> Armenian
<input type="checkbox"/> Cambodian/Khmer	<input type="checkbox"/> Cantonese	<input type="checkbox"/> Farsi/Persian
<input type="checkbox"/> Hmong/Miao	<input type="checkbox"/> Korean	<input type="checkbox"/> Mandarin
<input type="checkbox"/> Russian	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
<input type="checkbox"/> Declined		

Insurance (Check all that apply)

<input type="checkbox"/> CCS	<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> Commercial PPO	<input type="checkbox"/> Medi-Cal
<input type="checkbox"/> Point of Service/EPO	<input type="checkbox"/> No Insurance/Self Pay	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown

PATIENT ASSESSMENT

<p style="text-align: center;">Weight</p> <p style="text-align: center;"><input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (kg)</p> <p style="text-align: center;">or <input type="text"/> <input type="text"/> (lbs) <input type="text"/> <input type="text"/> (oz)</p>	<p style="text-align: center;">Length</p> <p style="text-align: center;"><input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (cm)</p> <p style="text-align: center;">or <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (in)</p>	<p style="text-align: center;">Head Circumference</p> <p style="text-align: center;"><input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (cm)</p> <p style="text-align: center;">or <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (in)</p>
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<p>Reason NOT Collected:</p> <p><input type="checkbox"/> Not Routinely Done</p> <p><input type="checkbox"/> Unable to Obtain</p> <p><input type="checkbox"/> Other</p>	<p>Reason NOT Collected:</p> <p><input type="checkbox"/> Not Routinely Done</p> <p><input type="checkbox"/> Unable to Obtain</p> <p><input type="checkbox"/> Other</p>	<p>Reason NOT Collected:</p> <p><input type="checkbox"/> Not Routinely Done</p> <p><input type="checkbox"/> Unable to Obtain</p> <p><input type="checkbox"/> Other</p>
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GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk?

Exclusively Some None

Living Arrangement of the Child

<input type="checkbox"/> Both Parents	<input type="checkbox"/> One Parent	<input type="checkbox"/> One Parent/Other Relatives
<input type="checkbox"/> Other Relatives/Not Parents	<input type="checkbox"/> Non Relative	<input type="checkbox"/> Foster/Adoptive Family
<input type="checkbox"/> Foster Family/CPS	<input type="checkbox"/> Pediatric Subacute Facility	<input type="checkbox"/> Other
<input type="checkbox"/> Unknown		

Education of Primary Caregiver

<input type="checkbox"/> <9 th Grade	<input type="checkbox"/> Some College	<input type="checkbox"/> Other
<input type="checkbox"/> Some High School	<input type="checkbox"/> College Degree	<input type="checkbox"/> Unknown
<input type="checkbox"/> High School Degree/GED	<input type="checkbox"/> Graduate School or Degree	<input type="checkbox"/> Declined

Caregiver Employment

<input type="checkbox"/> Full-Time	<input type="checkbox"/> Multiple Jobs	<input type="checkbox"/> Unknown
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Work From Home	<input type="checkbox"/> Declined
<input type="checkbox"/> Temporary	<input type="checkbox"/> Not Currently Employed	

Routine Child Care

None Yes Unknown

If Yes, Check all that apply:

<input type="checkbox"/> Child Care Outside of Home	<input type="checkbox"/> Home Babysitter/Nanny	<input type="checkbox"/> Not Used Routinely
<input type="checkbox"/> Specialized Medical Setting	<input type="checkbox"/> Other	

Caregiver Concerns of the Child

None Yes Unknown

If Yes, Check all that apply:

<input type="checkbox"/> Behavioral	<input type="checkbox"/> Calming/Crying	<input type="checkbox"/> Feeding & Growth
<input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Gastrointestinal/Stooling/Spitting-up	<input type="checkbox"/> Hearing
<input type="checkbox"/> Medications	<input type="checkbox"/> Motor Skills, Movement	<input type="checkbox"/> Pain
<input type="checkbox"/> Sensory Processing	<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Stress
<input type="checkbox"/> Sleeping/Napping	<input type="checkbox"/> Vision	<input type="checkbox"/> Other

(1) Core Visits: The HRIF Clinic has three core visits that take place during the following recommended time periods: **Visit #1** (4-8 months), **Visit #2** (12-16 months) and **Visit #3** (18-36 months). **NOTE:** Core Visit #1 is the initial first visit to the HRIF Clinic, even if the patient is older than 8 months corrected age.

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INTERVAL MEDICAL ASSESSMENT

Does the Child have a Primary Care Provider? No Yes Unknown

Does the Primary Care Provider Act as the Child's Medical Home? No Yes Unknown

Hospitalizations Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Number of Hospitalizations <input type="checkbox"/> Unknown															
	If Yes, Check all that apply															
	Hospitalization Reasons	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Gastrointestinal Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Meningitis Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nutrition/Inadequate Growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Seizure Disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Urinary Tract Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Number of Surgeries <input type="checkbox"/> Unknown		
	If Yes, Check all that apply		
<input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Inguinal Hernia Repair <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other Gastrointestinal Surgical Procedures <input type="checkbox"/> Other Surgical Procedures	<input type="checkbox"/> Circumcision <input type="checkbox"/> Retinopathy of Prematurity <input type="checkbox"/> Tympanostomy Tubes <input type="checkbox"/> Other Genitourinary Surgical Procedures <input type="checkbox"/> Unknown	<input type="checkbox"/> Gastrostomy Tube Placement <input type="checkbox"/> Shunt/Shunt Revision <input type="checkbox"/> Other ENT Surgical Procedures <input type="checkbox"/> Other Neurosurgical Procedures	

Medications Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
	If Yes, Check all that apply		
<input type="checkbox"/> Actigall <input type="checkbox"/> Antibiotics/Antifungal <input type="checkbox"/> Cardiac Medications <input type="checkbox"/> Diuretics <input type="checkbox"/> Inhaled Steroids (daily) <input type="checkbox"/> Nutrition Supplements (make selection): <input type="checkbox"/> Oral Steroids <input type="checkbox"/> Oxygen (if discontinued also enter chronologic post-natal age: _____ months _____ days) <input type="checkbox"/> Viagra (Pulmonary Hypertension) <input type="checkbox"/> Unknown	<input type="checkbox"/> Anti Reflux Medication <input type="checkbox"/> Antihypertensive <input type="checkbox"/> Chest Physiotherapy (daily) <input type="checkbox"/> Inhaled Bronchodilators (daily) <input type="checkbox"/> Inhaled Steroids (inter.) <input type="checkbox"/> Enteral Nutrition	<input type="checkbox"/> Anti Seizure Medication <input type="checkbox"/> Caffeine <input type="checkbox"/> Chest Physiotherapy (inter.) <input type="checkbox"/> Inhaled Bronchodilators (inter.) <input type="checkbox"/> Dietary Supplements <input type="checkbox"/> Other	

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INTERVAL MEDICAL ASSESSMENT - continue

Equipment Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown											
	If Yes, Check all that apply											
	<table border="0"> <tr> <td><input type="checkbox"/> Apnea/CR Monitor</td> <td><input type="checkbox"/> Braces/Castings/Orthotics</td> <td><input type="checkbox"/> Enteral Feeding Equipment</td> </tr> <tr> <td><input type="checkbox"/> Helmet</td> <td><input type="checkbox"/> Nebulizer</td> <td><input type="checkbox"/> Ostomy Supplies</td> </tr> <tr> <td><input type="checkbox"/> Tracheostomy</td> <td><input type="checkbox"/> Ventilator/CPAP/BiPAP</td> <td><input type="checkbox"/> Wheelchair</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Unknown</td> <td></td> </tr> </table>	<input type="checkbox"/> Apnea/CR Monitor	<input type="checkbox"/> Braces/Castings/Orthotics	<input type="checkbox"/> Enteral Feeding Equipment	<input type="checkbox"/> Helmet	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Ostomy Supplies	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Ventilator/CPAP/BiPAP	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
<input type="checkbox"/> Apnea/CR Monitor	<input type="checkbox"/> Braces/Castings/Orthotics	<input type="checkbox"/> Enteral Feeding Equipment										
<input type="checkbox"/> Helmet	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Ostomy Supplies										
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Ventilator/CPAP/BiPAP	<input type="checkbox"/> Wheelchair										
<input type="checkbox"/> Other	<input type="checkbox"/> Unknown											

MEDICAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Medical Services?

No (Skip to **Neurosensory Assessment**)
 Yes (Complete below)
 Unknown (Skip to **Neurosensory Assessment**)

Medical Service	Receiving/Status	Reasons (if Referred, but Not Receiving)
Audiology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Cardiology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Craniofacial	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Endocrinology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Gastroenterology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Hematology/Oncology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Metabolic/Genetics	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Nephrology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Neurology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason <input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available

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MEDICAL SERVICES REVIEW - continue

Neurosurgery	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Ophthalmology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Orthopedic	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Otolaryngology (ENT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Pulmonology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Surgery	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Urology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available

NEUROSENSORY ASSESSMENT

Vision Assessment History

Does the Child Have History of Retinopathy of Prematurity (ROP)? No Yes
 Eye Surgery and/or Treatment with Anti-VEGF (i.e. Avastin)? No Yes Scheduled Unknown
 Location of ROP: Unilateral Bilateral Unknown

Does the Child Have Visual Impairment?

No (Skip to **Hearing Assessment History**)

Yes **A. Impairment Due To: (check all that apply)**

No, Type of Impairment at Visit

Strabismus: Eye Surgery? No Yes Scheduled

Cataract: Eye Surgery? No Yes Scheduled

Retinoblastoma: Eye Surgery? No Yes Scheduled

Cortical Visual Impairment Refractive Errors

Nystagmus ROP

Other Unknown

B. Location of Impairment: Unilateral Bilateral Unknown

C. Corrective Lens(es) Recommended: No Yes Unknown

D. Corrective Lens(es) Used: No Yes Unknown

E. Is There Functional Vision? Yes No (complete below)

Location of "Blindness" Unilateral Bilateral Unknown

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**Required Field*

NEUROSENSORY ASSESSMENT - *continue*

Unknown Visual Impairment

Why is Visual Impairment Unknown?

- | | |
|--|---|
| <input type="checkbox"/> Exam Results Unknown | <input type="checkbox"/> No Ophthalmology Exam Performed |
| <input type="checkbox"/> Needs Referral for Exam | <input type="checkbox"/> Referred for Exam, Not Received |
| <input type="checkbox"/> Referred, but Service Not Available | <input type="checkbox"/> Referred, but Parent Declines/Refuses Services |
| <input type="checkbox"/> Referred, but Insurance/HMO Denied Services | <input type="checkbox"/> Referred, but Missed Appointment |
| <input type="checkbox"/> Referred for Functional Vision Assessment | <input type="checkbox"/> Functional Vision Assessment in Progress |

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?

No (Skip to **Neurologic Assessment**)

Yes **A. Is There Loss in One or Both Ears?** One Both Assessment in Progress Unknown

B. Does the Child Use an Assistive Listening Device (ALD):

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, ALD Recommended, but Not Received |
| <input type="checkbox"/> Yes, ALD Recommended and Received | <input type="checkbox"/> Unknown |

C. Type of ALD(s) Used (check all that apply)

- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> BAHA | <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> FM System |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

Unknown Hearing Loss

Why is Hearing Loss Unknown?

- | | |
|--|---|
| <input type="checkbox"/> Exam Results Unknown | <input type="checkbox"/> No Audiology Exam Performed |
| <input type="checkbox"/> Needs Referral for Exam | <input type="checkbox"/> Referred for Exam, Not Received |
| <input type="checkbox"/> Referred, but Service Not Available | <input type="checkbox"/> Referred, but Parent Declines/Refuses Services |
| <input type="checkbox"/> Referred, but Insurance/HMO Denied Services | <input type="checkbox"/> Referred, but Missed Appointment |

Hearing Assessment in Progress (Skip to **Neurologic Assessment**)

NEUROLOGIC ASSESSMENT

***Was a Neurologic Exam Performed During this Core Visit?**

Yes **Date Performed:** - - (MM-DD-YYYY)

No **Reason Why Exam NOT Performed:**

<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Examiner Not Available
<input type="checkbox"/> Known SEVERE Developmental Disability	<input type="checkbox"/> Primary Caregiver Refused	<input type="checkbox"/> Primary Language
<input type="checkbox"/> Significant Sensory Impairment/Loss	<input type="checkbox"/> Other Medical Condition	<input type="checkbox"/> Other

Summary of Neurologic Assessment

Normal (skip to **Developmental Assessment**)

Abnormal

Suspect

A. Oral Motor Function – Age Appropriate Responses for the Following:

- | | | | | |
|---------------------------|---------------------------------|-----------------------------------|----------------------------------|--|
| Feeding: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Swallowing: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Management of Secretions: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |

B. Muscle Tone

- | | | | | | |
|-------------------|---------------------------------|------------------------------------|------------------------------------|----------------------------------|--|
| Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Trunk | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Right Upper Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Left Upper Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Right Lower Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Left Lower Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |

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NEUROLOGIC ASSESSMENT - continue

C. Is There Scissoring of the Legs on Vertical Suspension? No Yes

D. Deep Tendon Reflexes:

Right Upper Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine	
Left Upper Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine	
Right Lower Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Clonus	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine
Left Lower Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Clonus	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine

E. Are Persistent Primitive Reflexes Present? No Yes Unknown

F. Are Abnormal Involuntary Movements Present? No Yes (check all that apply) Unknown

Ataxia Choreoathetoid Tremors

G. Quality of Movement and Posture: Normal Abnormal Suspect Unable to Determine

Functional Assessment

A. Bimanual Function Normal Abnormal Suspect Unable to Determine

Only Complete if the Child is ≥ 15 Months Adjusted Age

B. Right Pincer Grasp Normal Abnormal Suspect Unable to Determine

C. Left Pincer Grasp Normal Abnormal Suspect Unable to Determine

CEREBRAL PALSY (CP)

Does the Child Have Cerebral Palsy (CP)?

No (skip to **Developmental Assessment**)

Yes

Suspect

Gross Motor Function Classification System (GMFCS) Adjusted Age: (check only one)

Child 18 - 24 months of age adjusted for prematurity

Level I Level IV
 Level II Level V
 Level III Unable to Determine

Child ≥ 24 - 36 months of age adjusted for prematurity

Level I Level IV
 Level II Level V
 Level III Unable to Determine

Unable to Determine

DEVELOPMENTAL CORE VISIT ASSESSMENT

***Was a Developmental Assessment Screener or Test Performed During this Core Visit?**

Yes **Date Performed:** - - (MM-DD-YYYY)

No Reason Why Assessment **NOT** Performed:

<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Examiner Not Available
<input type="checkbox"/> Known SEVERE Developmental Disability	<input type="checkbox"/> Primary Caregiver Refused	<input type="checkbox"/> Primary Language
<input type="checkbox"/> Significant Sensory Impairment/Loss	<input type="checkbox"/> Other Medical Condition	<input type="checkbox"/> Other

DEVELOPMENTAL SCREENERS

Bayley Infant Neurodevelopmental Screener (BINS) – check appropriate range

Overall Classification: Low Risk Medium Risk High Risk Unable to Assess

Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - check appropriate range

Adaptive Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

STANDARD VISIT (SV) FORM

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DEVELOPMENTAL SCREENERS - *continue*

Bayley Scales of Infant and Toddler Development Screener (Bayley-III or Bayley 4) - check appropriate range					
Cognitive:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) - enter score					
Language Auditory (CLAMS)	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Cognitive Adaptive (CAT)	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Full Scale Capute	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Other/Not Listed Screener: _____ - check appropriate range					
Cognitive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Other:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development (Bayley-III or Bayley 4) "Hardcopy" - enter score			
Cognitive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive-Behavior Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Bayley Scales of Infant and Toddler Development (Bayley-III or Bayley 4) "Computer" - enter score			
Receptive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

STANDARD VISIT (SV) FORM

NAME: _____ (Last, First) **HRIF I.D. #** _____

DEVELOPMENTAL TESTS – *continue*

Battelle Developmental Inventory, 2nd Edition (BDI-2) - enter score					
Adaptive Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Personal-Social Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Receptive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Expressive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Communication Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Gross Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Motor Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Cognitive Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell) - enter score					
Language Development	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Gross Motor	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Personal-Social	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Adaptive	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Mullen Scales of Early Learning - AGS Edition (Mullen) - enter score					
Gross Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Visual Perception	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Receptive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Expressive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Early Learning Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Other/Not Listed Test: _____ - check appropriate range					
Cognitive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Other:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
AUTISM SPECTRUM SCREEN (Optional)					
Was an Autism Spectrum Screen Performed During this Visit?		<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>complete below</i>)		
Screening Tool Used:	<input type="checkbox"/> M-CHAT	<input type="checkbox"/> CSBS-DP	<input type="checkbox"/> PDDST-II	<input type="checkbox"/> Other/Not Listed	
Screening Results:	<input type="checkbox"/> Pass	<input type="checkbox"/> Did Not Pass			
Was the Infant Referred for Further Autism Spectrum Assessment?		<input type="checkbox"/> No	<input type="checkbox"/> Yes		

STANDARD VISIT (SV) FORM



NAME: _____ (Last, First) **HRIF I.D. #** _____

EARLY START (ES) PROGRAM

Is the Child Currently Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? (check only one)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No, Not Required | <input type="checkbox"/> No, Referred at Visit | <input type="checkbox"/> No, Referral Failure |
| <input type="checkbox"/> No, Pending Services | <input type="checkbox"/> No, Parent Refused Service | <input type="checkbox"/> No, Determined Ineligible by ES | <input type="checkbox"/> Unknown |

MEDICAL THERAPY PROGRAM (MTP)

Is the Child Currently Receiving Services Through CCS Medical Therapy Program (MTP)? (check only one)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No, Not Required | <input type="checkbox"/> No, Referred at Visit | <input type="checkbox"/> No, Referral Failure |
| <input type="checkbox"/> No, Pending Services | <input type="checkbox"/> No, Parent Refused Service | <input type="checkbox"/> No, Determined Ineligible by ES | <input type="checkbox"/> Unknown |

SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?

- No** (Skip to Resources and Social Concerns) **Yes** (Complete below) **Unknown**

Behavior Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Other	<input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Unknown	<input type="checkbox"/> Psychologist
Feeding Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Other	<input type="checkbox"/> Certified Lactation Consultant <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Unknown	<input type="checkbox"/> Home Health Agency <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Speech/Language Pathologist
Infant Development Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> MSW <input type="checkbox"/> Unknown	<input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech/Language Pathologist	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other
Hearing Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Audiologist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Unknown	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Teacher of the Deaf	<input type="checkbox"/> ENT <input type="checkbox"/> Other
Nutritional Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Certified Lactation Consultant <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Unknown	<input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Physician <input type="checkbox"/> Other

STANDARD VISIT (SV) FORM



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SPECIAL SERVICES REVIEW - <i>continue</i>		
Occupational Therapy (OT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Physical Therapy (PT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Speech/Language Communication	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> American Sign Language <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Other <input type="checkbox"/> Teacher of the Deaf <input type="checkbox"/> Unknown	
Social Work Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Physician <input type="checkbox"/> Unknown <input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> MSW <input type="checkbox"/> Psychologist <input type="checkbox"/> Other	
Visiting, Public Health, and/or Home Nursing	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> Licensed Vocational Nurse <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Unknown	
Vision Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-REFERRED <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	<u>Service Provider:</u> <input type="checkbox"/> Low Vision Specialist (Optometrist) <input type="checkbox"/> Orientation & Mobility Specialist <input type="checkbox"/> Other <input type="checkbox"/> Low Vision Specialist (Ophthalmologist) <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Unknown <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Teacher of the Visually Impaired	

STANDARD VISIT (SV) FORM



NAME: _____ (Last, First) **HRIF I.D. #** _____

***Required Field**

SOCIAL CONCERNS AND RESOURCES

Caregiver-Child Disruptions or Concerns <i>Single parent, divorce, prolonged separation (incarceration, military service) multiple changes in caregivers/daycare, caregiver chronic illness</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, Referral Not Necessary <input type="checkbox"/> Yes, Referred to Social Worker <input type="checkbox"/> Yes, Referred to Other Community Resources
Economic/Environmental Concerns/Stressors <i>Housing insecurity, lack of resources-\$\$, insurance (or high co-pay), lack of reliable transportation for medical needs</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, Referral Not Necessary <input type="checkbox"/> Yes, Referred to Social Worker <input type="checkbox"/> Yes, Referred to Other Community Resources
Community & Relationship Concerns <i>Emotional support from family/friends, supportive and safe intimate relationship, safe neighborhood, and resources for needs</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, Referral Not Necessary <input type="checkbox"/> Yes, Referred to Social Worker <input type="checkbox"/> Yes, Referred to Other Community Resources
Parent-Child Concerns <i>Feeding & growth, calming, behavior, sleep, other</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, Referral Not Necessary <input type="checkbox"/> Yes, Referred to Social Worker <input type="checkbox"/> Yes, Referred to Other Community Resources

CHILD PROTECTIVE SERVICES (CPS)

Is a Child Protective Services Case Currently Opened?

No
 Yes
 Referred at Time of Visit

OTHER MEDICAL CONDITIONS

Were there Additional Medical Conditions Identified that may Impact the Child's Outcome? No Yes (complete below)

(check all categories that apply and provide a description of the diagnosis)

<input type="checkbox"/> Cardiovascular and Circulatory:
<input type="checkbox"/> Endocrine and Metabolic:
<input type="checkbox"/> Eye, Ear, Nose:
<input type="checkbox"/> Gastrointestinal and Hepatobiliary:
<input type="checkbox"/> Genetic:
<input type="checkbox"/> Hematologic, Immunologic, or Oncologic/Neoplasm:
<input type="checkbox"/> Infectious Diseases:
<input type="checkbox"/> Injuries, Accident, Poisoning:
<input type="checkbox"/> Renal and Genitourinary Tract:
<input type="checkbox"/> Respiratory System:
<input type="checkbox"/> Nervous System:
<input type="checkbox"/> Other:

*DISPOSITION (Required Field)

Scheduled to Return
 Will be Followed by Another CCS HRIF Clinic (1)

Completed HRIF Core Visits, Scheduled to Return

DISCHARGED:

<input type="checkbox"/> Graduated	<input type="checkbox"/> Closed Out of Program
<input type="checkbox"/> Family Moving Out of State/Country	<input type="checkbox"/> Family Withdrew Prior To Completion
<input type="checkbox"/> Will be Followed Elsewhere	<input type="checkbox"/> Completed HRIF Core Visits, Referred for Additional Resources

(1) Submit a Help Desk ticket at: <https://www.cpqcchelp.org/>, to request to transfer the patient record to another CCS HRIF Clinic. Include in the ticket request the patient's "HRIF ID Number", "Birth Weight or Gestational Age" and the "CCS HRIF Clinic, where the patient will be transferred for follow-up services".

