# STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**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:** ☐ Spanish ☐ Cambodian/Khmer ☐ Hmong/Miao ☐ Russian ☐ Vietnamese ☐ Declined | ☐ Arabic ☐ Cantonese ☐ Korean ☐ Sign Language ☐ Other | ☐ Armenian ☐ Farsi/Persian ☐ Mandarin ☐ Tagalog ☐ Unknown |
| **Insurance** (Check all that apply) | | | |
| ☐ CCS | ☐ Commercial HMO | ☐ Commercial PPO | ☐ Medi-Cal |
| ☐ Point of Service/EPO | ☐ No Insurance/Self Pay | ☐ Other | ☐ Unknown |

## PATIENT ASSESSMENT

| **Weight** | **Length** | **Head Circumference** |
|---|---|---|
| ☐☐.☐☐ (kg) or ☐☐ (lbs) ☐☐ (oz) | ☐☐☐.☐ (cm) or ☐☐.☐☐ (in) | ☐☐☐.☐ (cm) or ☐☐.☐☐ (in) |
| **Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other | **Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other | **Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other |

## GENERAL ASSESSMENT

| | | | |
|---|---|---|---|
| **Is the Child Currently Receiving Breastmilk?** | ☐ Exclusively | ☐ Some | ☐ None |
| **Living Arrangement of the Child** | ☐ Both Parents ☐ Other Relatives/Not Parents ☐ Foster Family/CPS ☐ Unknown | ☐ One Parent ☐ Non Relative ☐ Pediatric Subacute Facility | ☐ One Parent/Other Relatives ☐ Foster/Adoptive Family ☐ Other |
| **Education of Primary Caregiver** | ☐ <9th Grade ☐ Some High School ☐ High School Degree/GED | ☐ Some College ☐ College Degree ☐ Graduate School or Degree | ☐ Other ☐ Unknown ☐ Declined |
| **Caregiver Employment** | ☐ Full-Time ☐ Part-Time ☐ Temporary | ☐ Multiple Jobs ☐ Work From Home ☐ Not Currently Employed | ☐ Unknown ☐ Declined |
| **Routine Child Care** | ☐ **None** ☐ **Yes** ☐ **Unknown** **If Yes, Check all that apply:** ☐ Child Care Outside of Home ☐ Specialized Medical Setting | ☐ Home Babysitter/Nanny ☐ Other | ☐ Not Used Routinely |
| **Caregiver Concerns of the Child** | ☐ **None** ☐ **Yes** ☐ **Unknown** **If Yes, Check all that apply:** ☐ Behavioral ☐ Frequent Illness ☐ Medications ☐ Sensory Processing ☐ Sleeping/Napping | ☐ Calming/Crying ☐ Gastrointestinal/Stooling/Spitting-up ☐ Motor Skills, Movement ☐ Speech & Language ☐ Vision | ☐ Feeding & Growth ☐ Hearing ☐ Pain ☐ Stress ☐ Other |

(1) Core Visits: The HRIF Program 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 follow-up program, even if the patient is older than 8 months corrected age, *HRIF-QCI: Manual of Definitions.*

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HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

## 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

☐ **No** ☐ **Yes:** ☐☐ Number of Hospitalizations ☐ **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) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Meningitis Infection(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nutrition/Inadequate Growth | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Respiratory Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizure Disorder(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Urinary Tract Infection(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Infection(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Medical Rehospitalization(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unknown | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Having Surgeries During Hospitalization | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

### Surgeries Since Last Visit

☐ **No** ☐ **Yes:** ☐☐ Number of Surgeries ☐ **Unknown**

**If Yes, Check all that apply**

☐ Cardiac Surgery
☐ Inguinal Hernia Repair
☐ Tracheostomy
☐ Other Gastrointestinal Surgical Procedures
☐ Other Surgical Procedures
☐ Circumcision
☐ Retinopathy of Prematurity
☐ Tympanostomy Tubes
☐ Other Genitourinary Surgical Procedures
☐ Unknown
☐ Gastrostomy Tube Placement
☐ Shunt/Shunt Revision
☐ Other ENT Surgical Procedures
☐ Other Neurosurgical Procedures

### Medications Since Last Visit

☐ **No** ☐ **Yes** ☐ **Unknown**

**If Yes, Check all that apply**

☐ Actigall
☐ Antibiotics/Antifungal
☐ Cardiac Medications
☐ Diuretics
☐ Inhaled Steroids (daily)
☐ Anti Reflux Medication
☐ Antihypertensive
☐ Chest Physiotherapy (daily)
☐ Inhaled Bronchodilators (daily)
☐ Inhaled Steroids (inter.)
☐ Anti Seizure Medication
☐ Caffeine
☐ Chest Physiotherapy (inter.)
☐ Inhaled Bronchodilators (inter.)
☐ Nutrition Supplements (make selection): ☐ Enteral Nutrition ☐ Dietary Supplements
☐ Oral Steroids
☐ Oxygen (if discontinued also enter chronologic post-natal age: _____ months _____ days)
☐ Viagra (Pulmonary Hypertension)
☐ Synagis/Palivizumab
☐ Other
☐ Unknown

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## INTERVAL MEDICAL ASSESSMENT - *continue*

**Equipment Since Last Visit**

☐ **No** ☐ **Yes** ☐ **Unknown**

**If Yes, Check all that apply**

☐ Apnea/CR Monitor
☐ Braces/Castings/Orthotics
☐ Enteral Feeding Equipment
☐ Helmet
☐ Nebulizer
☐ Ostomy Supplies
☐ Tracheostomy
☐ Ventilator/CPAP/BiPAP
☐ Wheelchair
☐ Other
☐ 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**)

| | | |
|---|---|---|
| **Audiology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Cardiology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Craniofacial** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Endocrinology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Gastroenterology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Hematology/ Oncology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Metabolic/ Genetics** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Nephrology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |
| **Neurology** | ☐ **Does Not Need**<br>☐ **Receiving**<br>☐ **Complete**<br>☐ **Referred at Time of Visit** | **Referred, but Not Receiving** (check reason)<br>☐ Missed Appointment<br>☐ Re-Referred<br>☐ Parent Declined/Refused Service<br>☐ Other/Unknown Reason<br>☐ Visit Pending<br>☐ Insurance/HMO Denied<br>☐ Service Not Available |

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

## MEDICAL SERVICES REVIEW - *continue*

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

## 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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## NEUROSENSORY ASSESSMENT - *continue*

☐ **Unknown Visual Impairment**

**Why is Visual Impairment Unknown?**

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but Insurance/HMO Denied Services
- ☐ Referred for Functional Vision Assessment
- ☐ No Ophthalmology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ Referred, but Missed Appointment
- ☐ 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):**

- ☐ No
- ☐ Yes, ALD Recommended and Received
- ☐ Yes, ALD Recommended, but Not Received
- ☐ Unknown

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

- ☐ BAHA
- ☐ Hearing Aid
- ☐ Cochlear Implant
- ☐ Other
- ☐ FM System
- ☐ Unknown

☐ **Unknown Hearing Loss**

**Why is Hearing Loss Unknown?**

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but Insurance/HMO Denied Services
- ☐ No Audiology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ 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:**

- ☐ Acute Illness
- ☐ Known SEVERE Developmental Disability
- ☐ Significant Sensory Impairment/Loss
- ☐ Behavior Problems
- ☐ Primary Caregiver Refused
- ☐ Other Medical Condition
- ☐ Examiner Not Available
- ☐ Primary Language
- ☐ Other

**Summary of Neurologic Assessment**

☐ **Normal** (skip to **Developmental Assessment**)

☐ **Abnormal**

☐ **Suspect**

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

| | | | | |
|---|---|---|---|---|
| Feeding: | ☐ Normal | ☐ Abnormal | ☐ Suspect | ☐ Unable to Determine |
| Swallowing: | ☐ Normal | ☐ Abnormal | ☐ Suspect | ☐ Unable to Determine |
| Management of Secretions: | ☐ Normal | ☐ Abnormal | ☐ Suspect | ☐ Unable to Determine |

**B. Muscle Tone**

| | | | | | |
|---|---|---|---|---|---|
| Neck | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ Unable to Determine |
| Trunk | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ Unable to Determine |
| Right Upper Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ Unable to Determine |
| Left Upper Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ Unable to Determine |
| Right Lower Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ Unable to Determine |
| Left Lower Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | ☐ 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: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | | ☐ Unable to Determine |
| Left Upper Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Suspect | | ☐ Unable to Determine |
| Right Lower Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Clonus | ☐ Suspect | ☐ Unable to Determine |
| Left Lower Limb: | ☐ Normal | ☐ Increased | ☐ Decreased | ☐ Clonus | ☐ Suspect | ☐ 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* | | *Child ≥ 24 - 36 months of age adjusted for prematurity* | |
|---|---|---|---|
| ☐ Level I | ☐ Level IV | ☐ Level I | ☐ Level IV |
| ☐ Level II | ☐ Level V | ☐ Level II | ☐ Level V |
| ☐ Level III | ☐ Unable to Determine | ☐ 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:

| | | |
|---|---|---|
| ☐ Acute Illness | ☐ Behavior Problems | ☐ Examiner Not Available |
| ☐ Known SEVERE Developmental Disability | ☐ Primary Caregiver Refused | ☐ Primary Language |
| ☐ Significant Sensory Impairment/Loss | ☐ Other Medical Condition | ☐ 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: | ☐ Pass | ☐ Refer | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social Domain: | ☐ Pass | ☐ Refer | ☐ Unable to Assess | ☐ Did Not Assess |
| Communication: | ☐ Pass | ☐ Refer | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Domain: | ☐ Pass | ☐ Refer | ☐ Unable to Assess | ☐ Did Not Assess |
| Cognitive Domain: | ☐ Pass | ☐ Refer | ☐ Unable to Assess | ☐ Did Not Assess |

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## DEVELOPMENTAL SCREENERS - *continue*

| **Bayley Scales of Infant and Toddler Development Screening Test, 3rd Edition (Bayley-III Sceener)** - *check appropriate range* | | | | | |
|---|---|---|---|---|---|
| Cognitive: | ☐ Competent | ☐ Emerging | ☐ At Risk | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language: | ☐ Competent | ☐ Emerging | ☐ At Risk | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language: | ☐ Competent | ☐ Emerging | ☐ At Risk | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor: | ☐ Competent | ☐ Emerging | ☐ At Risk | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor: | ☐ Competent | ☐ Emerging | ☐ At Risk | ☐ Unable to Assess | ☐ 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: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Cognitive Adaptive (CAT) | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Full Scale Capute | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

| **Other/Not Listed Screener:** _____ – *check appropriate range* | | | | | |
|---|---|---|---|---|---|
| Cognitive: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Language Composite: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Composite: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Adaptive: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Other: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |

## DEVELOPMENTAL TESTS

| **Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Hardcopy"** - *enter score* | | | |
|---|---|---|---|
| Cognitive Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Language Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Social-Emotional Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Adaptive-Behavior Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

| **Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Computer"** - *enter score* | | | |
|---|---|---|---|
| Receptive Language Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor Scaled Score | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Cognitive Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Language Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Adaptive Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

# STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

## DEVELOPMENTAL TESTS – *continue*

| **Battelle Developmental Inventory, 2nd Edition (BDI-2)** - *enter score* | | | |
|---|---|---|---|
| Adaptive Domain | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social Domain | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Communication Domain | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Domain | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Cognitive Domain | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

| **Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell)** - *enter score* | | | |
|---|---|---|---|
| Language Development | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Adaptive | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

| **Mullen Scales of Early Learning - AGS Edition (Mullen)** - *enter score* | | | |
|---|---|---|---|
| Gross Motor Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Visual Perception | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language Scale | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |
| Early Learning Composite | Score: _____ | ☐ Unable to Assess | ☐ Did Not Assess |

| **Other/Not Listed Test:**_____ - *check appropriate range* | | | | | |
|---|---|---|---|---|---|
| Cognitive: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Receptive Language: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Expressive Language: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Language Composite: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Gross Motor: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Fine Motor: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Motor Composite: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Personal-Social: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Adaptive: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |
| Other: | ☐ Normal | ☐ Mild/Moderate | ☐ Significant | ☐ Unable to Assess | ☐ Did Not Assess |

## AUTISM SPECTRUM SCREEN (Optional)

| | | | | |
|---|---|---|---|---|
| **Was an Autism Spectrum Screen Performed During this Visit?** | | | ☐ **No** | ☐ **Yes** *(complete below)* |
| ***Screening Tool Used:*** | ☐ M-CHAT | ☐ CSBS-DP | ☐ PDDST-II | ☐ Other/Not Listed |
| ***Screening Results:*** | ☐ Pass | ☐ Did Not Pass | | |
| **Was the Infant Referred for Further Autism Spectrum Assessment?** | | | ☐ **No** | ☐ **Yes** |

# STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

**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)*

☐ **Yes** ☐ No, **Not Required** ☐ No, **Referred at Visit** ☐ No, **Referral Failure**
☐ No, **Pending Services** ☐ No, **Parent Refused Service** ☐ No, **Determined Ineligible by ES** ☐ **Unknown**

## MEDICAL THERAPY PROGRAM (MTP)

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

☐ **Yes** ☐ No, **Not Required** ☐ No, **Referred at Visit** ☐ No, **Referral Failure**
☐ No, **Pending Services** ☐ No, **Parent Refused Service** ☐ No, **Determined Ineligible by ES** ☐ **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

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)
☐ Missed Appointment ☐ Waiting List / Visit Pending
☐ Re-Referred ☐ Insurance/HMO Denied
☐ Service Not Available ☐ Service Cancelled
☐ Parent Declined/Refused Service ☐ Other/Unknown Reason

***Service Provider:***
☐ Early Intervention Specialist ☐ Licensed Clinical Social Worker ☐ Psychologist
☐ Other ☐ Unknown

### Feeding Therapy

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)
☐ Missed Appointment ☐ Waiting List / Visit Pending
☐ Re-Referred ☐ Insurance/HMO Denied
☐ Service Not Available ☐ Service Cancelled
☐ Parent Declined/Refused Service ☐ Other/Unknown Reason

***Service Provider:***
☐ Early Intervention Specialist ☐ Certified Lactation Consultant ☐ Home Health Agency
☐ Occupational Therapist ☐ Physical Therapist ☐ Public Health Nurse
☐ Registered Dietitian ☐ Registered Nurse ☐ Speech/Language Pathologist
☐ Other ☐ Unknown

### Infant Development Services

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)
☐ Missed Appointment ☐ Waiting List / Visit Pending
☐ Re-Referred ☐ Insurance/HMO Denied
☐ Service Not Available ☐ Service Cancelled
☐ Parent Declined/Refused Service ☐ Other/Unknown Reason

***Service Provider:***
☐ Early Intervention Specialist ☐ Licensed Clinical Social Worker ☐ Occupational Therapist
☐ Physical Therapist ☐ Psychologist ☐ Registered Nurse
☐ MSW ☐ Speech/Language Pathologist ☐ Other
☐ Unknown

### Hearing Services

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)
☐ Missed Appointment ☐ Waiting List / Visit Pending
☐ Re-Referred ☐ Insurance/HMO Denied
☐ Service Not Available ☐ Service Cancelled
☐ Parent Declined/Refused Service ☐ Other/Unknown Reason

***Service Provider:***
☐ Audiologist ☐ Early Intervention Specialist ☐ ENT
☐ Speech/Language Pathologist ☐ Teacher of the Deaf ☐ Other
☐ Unknown

### Nutritional Therapy

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)
☐ Missed Appointment ☐ Waiting List / Visit Pending
☐ Re-Referred ☐ Insurance/HMO Denied
☐ Service Not Available ☐ Service Cancelled
☐ Parent Declined/Refused Service ☐ Other/Unknown Reason

***Service Provider:***
☐ Certified Lactation Consultant ☐ Public Health Nurse ☐ Physician
☐ Registered Dietitian ☐ Registered Nurse ☐ Other
☐ Unknown

# STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

## SPECIAL SERVICES REVIEW - *continue*

### Occupational Therapy (OT)

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ Occupational Therapist ☐ Other ☐ Unknown

### Physical Therapy (PT)

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ Physical Therapist ☐ Other ☐ Unknown

### Speech/Language Communication

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ American Sign Language ☐ Early Intervention Specialist ☐ Teacher of the Deaf
☐ Speech/Language Pathologist ☐ Other ☐ Unknown

### Social Work Intervention

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ Licensed Clinical Social Worker ☐ Marriage & Family Therapist ☐ Psychologist
☐ Physician ☐ MSW ☐ Other
☐ Unknown

### Visiting, Public Health, and/or Home Nursing

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ Licensed Vocational Nurse ☐ Physician ☐ Public Health Nurse
☐ Registered Nurse ☐ Other ☐ Unknown

### Vision Services

☐ **Does Not Need**
☐ **Receiving**
☐ **Complete**
☐ **Referred at Time of Visit**

**Referred, but Not Receiving** (check reason)

☐ Missed Appointment
☐ Re-Referred
☐ Service Not Available
☐ Parent Declined/Refused Service
☐ Waiting List / Visit Pending
☐ Insurance/HMO Denied
☐ Service Cancelled
☐ Other/Unknown Reason

***Service Provider:***

☐ Low Vision Specialist (Optometrist) ☐ Low Vision Specialist (Ophthalmologist) ☐ Occupational Therapist
☐ Orientation & Mobility Specialist ☐ Physical Therapist ☐ Teacher of the Visually Impaired
☐ Other ☐ Unknown

# STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

***Required Field**

## SOCIAL CONCERNS AND RESOURCES

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

- ☐ **Cardiovascular and Circulatory:**
- ☐ **Endocrine and Metabolic:**
- ☐ **Eye, Ear, Nose:**
- ☐ **Gastrointestinal and Hepatobiliary:**
- ☐ **Genetic:**
- ☐ **Hematologic, Immunologic, or Oncologic/Neoplasm:**
- ☐ **Infectious Diseases:**
- ☐ **Injuries, Accident, Poisoning:**
- ☐ **Renal and Genitourinary Tract:**
- ☐ **Respiratory System:**
- ☐ **Nervous System:**
- ☐ **Other:**

## *DISPOSITION *(Required Field)*

☐ Scheduled to Return
☐ Will be Followed by Another CCS HRIF Program (1)
☐ Completed HRIF Core Visits, Scheduled to Return

**DISCHARGED:**

☐ Graduated
☐ Closed Out of Program
☐ Family Moving Out of State/Country
☐ Family Withdrew Prior To Completion
☐ Will be Followed Elsewhere
☐ Completed HRIF Core Visits, Referred for Additional Resources

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