

# ADDITIONAL VISIT (AV) FORM



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

*\*Required Field*

**\*DATE OF ADDITIONAL VISIT:**   -   -     (MM-DD-YYYY)

### REASON FOR ADDITIONAL VISIT (Required Field)

- |  |  |
|--|--|
| <input type="checkbox"/> Social Risk     | <input type="checkbox"/> Concern With Neuro/Developmental Course |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Other: _____                            |

### DISPOSITION (Required Field)

- |  |  |
|--|--|
| <input type="checkbox"/> Scheduled To Return | <input type="checkbox"/> Will Be Followed by Another CCS HRIF Clinic (1) |
|--|--|

**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 |

### HOSPITAL/CENTER INFORMATION (Optional)

<b>Hospital Specific Medical I.D. #</b> <input type="text"/>		
<b>Infant's First Name:</b>		
<b>Infant's Last Name:</b>		
<b>Infant's AKA-1 Last Name:</b>		
<b>Infant's AKA-2 Last Name:</b>		
<b>Primary Caregiver's First Name:</b>		
<b>Primary Caregiver's Last Name:</b>		
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b> CA	<b>Zip Code:</b> <input type="text"/>
<b>Home Phone Number:</b> ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<b>Alternate Street Address:</b>		
<b>Alternate City:</b>	<b>State:</b> CA	<b>Zip Code:</b> <input type="text"/>
<b>Alternate Phone Number:</b> ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

(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".

