ADDITIONAL VISIT (AV) FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

*Required Field

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

*REASON FOR ADDITIONAL VISIT *(Required Field)*

- ☐ Social Risk
- ☐ Case Management
- ☐ Concern With Neuro/Developmental Course
- ☐ Other: _____

*DISPOSITION *(Required Field)*

- ☐ Scheduled To Return
- ☐ Will Be Followed by Another CCS HRIF Program (1)

DISCHARGED:

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

HOSPITAL/CENTER INFORMATION (Optional)

Hospital Specific Medical I.D. # ☐☐☐☐☐☐☐☐☐☐

Infant's First Name:

Infant's Last Name:

Infant's AKA-1 Last Name:

Infant's AKA-2 Last Name:

Primary Caregiver's First Name:

Primary Caregiver's Last Name:

Street Address:

City: **State:** CA **Zip Code:** ☐☐☐☐☐

Home Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

Alternate Street Address:

Alternate City: **State:** CA **Zip Code:** ☐☐☐☐☐

Alternate Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

(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"***.