

# CLIENT NOT SEEN/DISCHARGE (CNSD) FORM

## HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

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

**\*Required Field**

**\*DATE CLIENT NOT SEEN/DISCHARGE:**   -   -     (MM-DD-YYYY)

<b>*CATEGORY (Required Field)</b>		
<input type="checkbox"/> No Appointment Scheduled	<input type="checkbox"/> Core Visit Appointment Scheduled	<input type="checkbox"/> Discharged
<b>*REASON FOR CLIENT NOT SEEN / DISCHARGE (Required Field)</b>		
<input type="checkbox"/> Infant Illness	<input type="checkbox"/> Parent Declines Due to Cost	
<input type="checkbox"/> Infant Hospitalized	<input type="checkbox"/> Insurance Authorization Problems	
<input type="checkbox"/> Infant Referred to Another HRIF Program	<input type="checkbox"/> CCS Denied	
<input type="checkbox"/> Infant/Family Moved Within California	<input type="checkbox"/> Lack of Transportation	
<input type="checkbox"/> Infant/Family Moved Out of State	<input type="checkbox"/> Lost to Follow-up	
<input type="checkbox"/> Infant Expired	<input type="checkbox"/> Unable to Contact	
<input type="checkbox"/> Parent Illness	<input type="checkbox"/> Other: <input style="width: 100%;" type="text"/>	
<input type="checkbox"/> Parent Refused	<input type="checkbox"/> No Show/Reason Unknown	
<input type="checkbox"/> Parent Competing Priorities		
<b>*DISPOSITION (Required Field)</b>		
<input type="checkbox"/> Scheduled Appointment	<input type="checkbox"/> Will Schedule Appointment	<input type="checkbox"/> Will Be Followed by Another CCS HRIF Program (1)
<b>DISCHARGED:</b> <input type="checkbox"/> Family Moving Out of State/Country <input type="checkbox"/> Will be Followed Elsewhere <input type="checkbox"/> Closed Out of Program		
<b>HOSPITAL/CENTER INFORMATION (Optional)</b>		
Hospital Specific Medical I.D. # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Home Phone Number: ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Alternate Street Address: _____		
Alternate City: _____	State: CA	Zip Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Alternate Phone Number: ( <input type="text"/> <input type="text"/> <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 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".

