

ADDITIONAL VISIT (AV) FORM



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

**Required Field*

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

*** This visit was conducted:** In-person Telehealth (audio + video observation) Phone Only

* REASON FOR ADDITIONAL VISIT (Required Field)

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

* DISPOSITION (Required Field)

Scheduled To Return Will Be Followed by Another CCS HRIF Clinic (1)

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

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 Desk ticket at: <https://www.cpgcchelp.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".