

# 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".