CLIENT NOT SEEN / DISCHARGE (CNSD) FORM

HIGH RISK INFANT FOLLOW-UP

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

*Required Field

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

*CATEGORY *(Required Field)*

☐ No Appointment Scheduled	☐ Core Visit Appointment Scheduled	☐ Discharged

*REASON FOR CLIENT NOT SEEN / DISCHARGE *(Required Field)*

- ☐ Appt Cancelled/COVID-19 Related
- ☐ Infant Illness
- ☐ Infant Hospitalized
- ☐ Infant Referred to Another HRIF Clinic
- ☐ Infant/Family Moved Within California
- ☐ Infant/Family Moved Out of State
- ☐ Infant Expired
- ☐ Parent Illness
- ☐ Parent Refused
- ☐ Parent Competing Priorities
- ☐ Parent Declines Due to Cost
- ☐ Insurance Authorization Problems
- ☐ CCS Denied
- ☐ Lack of Transportation
- ☐ Lost to Follow-up
- ☐ Unable to Contact
- ☐ Other:
- ☐ No Show/Reason Unknown

*DISPOSITION *(Required Field)*

☐ Scheduled Appointment ☐ Will Schedule Appointment ☐ Will Be Followed by Another CCS HRIF Clinic (1)

DISCHARGED: ☐ Family Moving Out of State/Country ☐ Will be Followed Elsewhere ☐ Closed Out of Program

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.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"***.