

# CLIENT NOT SEEN / DISCHARGE (CNSD) FORM



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

<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 Clinic (1)

**DISCHARGED:**     Family Moving Out of State/Country     Will be Followed Elsewhere     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) Learn [How To Transfer a Record to Another CCS HRIF Clinic](#).