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.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"***.