

CLIENT NOT SEEN / DISCHARGE (CNSD) FORM

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

***Required Field**

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

| *CATEGORY (Required Field) | | |
|--|---|--|
| <input type="checkbox"/> No Appointment Scheduled | <input type="checkbox"/> Core Visit Appointment Scheduled | <input type="checkbox"/> Discharged |
| *REASON FOR CLIENT NOT SEEN / DISCHARGE (Required Field) | | |
| <input type="checkbox"/> Appt Cancelled/COVID-19 Related | <input type="checkbox"/> Parent Declines Due to Cost | |
| <input type="checkbox"/> Infant Illness | <input type="checkbox"/> Insurance Authorization Problems | |
| <input type="checkbox"/> Infant Hospitalized | <input type="checkbox"/> CCS Denied | |
| <input type="checkbox"/> Infant Referred to Another HRIF Clinic | <input type="checkbox"/> Lack of Transportation | |
| <input type="checkbox"/> Infant/Family Moved Within California | <input type="checkbox"/> Lost to Follow-up | |
| <input type="checkbox"/> Infant/Family Moved Out of State | <input type="checkbox"/> Unable to Contact | |
| <input type="checkbox"/> Infant Expired | <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Parent Illness | <input style="width: 100%;" type="text"/> | |
| <input type="checkbox"/> Parent Refused | | |
| <input type="checkbox"/> Parent Competing Priorities | <input type="checkbox"/> No Show/Reason Unknown | |
| *DISPOSITION (Required Field) | | |
| <input type="checkbox"/> Scheduled Appointment | <input type="checkbox"/> Will Schedule Appointment | <input type="checkbox"/> Will Be Followed by Another CCS HRIF Clinic (1) |
| DISCHARGED: <input type="checkbox"/> Family Moving Out of State/Country <input type="checkbox"/> Will be Followed Elsewhere <input type="checkbox"/> Closed Out of Program | | |
| HOSPITAL/CENTER INFORMATION (Optional) | | |
| 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) Submit a Help Desk ticket at: <https://www.cpqchelp.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".

