

STANDARD VISIT (SV) FORM

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

**Required Field*

***Date of Visit:** - - (MM-DD-YYYY)

VISIT ASSESSMENT

*Core Visit (1)	<input type="checkbox"/> #1 (4-8 months)	<input type="checkbox"/> #2 (12-16 months)	<input type="checkbox"/> #3 (18-36 months)
Infant enrolled in a CCS clinic other than the HRIF Program:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Zip Code of Primary Caregiver: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Chronological Age: <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Days		Adjusted Age: <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Days	
Interpreter Used	<input type="checkbox"/> No		
	<input type="checkbox"/> Yes: <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Cambodian/Khmer <input type="checkbox"/> Cantonese <input type="checkbox"/> Farsi/Persian <input type="checkbox"/> Hmong/Miao <input type="checkbox"/> Korean <input type="checkbox"/> Mandarin <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined		
Insurance (Check all that apply)			
<input type="checkbox"/> CCS	<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> Commercial PPO	<input type="checkbox"/> Medi-Cal
<input type="checkbox"/> Point of Service/EPO	<input type="checkbox"/> No Insurance/Self Pay	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown

PATIENT ASSESSMENT

Weight <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (kg) or <input type="text"/> <input type="text"/> (lbs) <input type="text"/> <input type="text"/> (oz)		Length <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (cm) or <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (in)		Head Circumference <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (cm) or <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (in)	
Reason NOT Collected:	<input type="checkbox"/> Not Routinely Done <input type="checkbox"/> Unable to Obtain <input type="checkbox"/> Other	Reason NOT Collected:	<input type="checkbox"/> Not Routinely Done <input type="checkbox"/> Unable to Obtain <input type="checkbox"/> Other	Reason NOT Collected:	<input type="checkbox"/> Not Routinely Done <input type="checkbox"/> Unable to Obtain <input type="checkbox"/> Other

GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk?	<input type="checkbox"/> Exclusively	<input type="checkbox"/> Some	<input type="checkbox"/> None
Living Arrangement of the Child	<input type="checkbox"/> Both Parents <input type="checkbox"/> Other Relatives/Not Parents <input type="checkbox"/> Foster Family/CPS <input type="checkbox"/> Unknown	<input type="checkbox"/> One Parent <input type="checkbox"/> Non Relative <input type="checkbox"/> Pediatric Subacute Facility	<input type="checkbox"/> One Parent/Other Relatives <input type="checkbox"/> Foster/Adoptive Family <input type="checkbox"/> Other
Education of Primary Caregiver	<input type="checkbox"/> <9 th Grade <input type="checkbox"/> Some High School <input type="checkbox"/> High School Degree/GED	<input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate School or Degree	<input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined
Caregiver Employment	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary	<input type="checkbox"/> Multiple Jobs <input type="checkbox"/> Work From Home <input type="checkbox"/> Not Currently Employed	<input type="checkbox"/> Unknown <input type="checkbox"/> Declined
Routine Child Care	<input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If Yes, Check all that apply: <input type="checkbox"/> Child Care Outside of Home <input type="checkbox"/> Specialized Medical Setting	<input type="checkbox"/> Home Babysitter/Nanny <input type="checkbox"/> Other	<input type="checkbox"/> Not Used Routinely
Caregiver Concerns of the Child	<input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If Yes, Check all that apply: <input type="checkbox"/> Behavioral <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Medications <input type="checkbox"/> Sensory Processing <input type="checkbox"/> Sleeping/Napping	<input type="checkbox"/> Calming/Crying <input type="checkbox"/> Gastrointestinal/Stooling/Spitting-up <input type="checkbox"/> Motor Skills, Movement <input type="checkbox"/> Speech & Language <input type="checkbox"/> Vision	<input type="checkbox"/> Feeding & Growth <input type="checkbox"/> Hearing <input type="checkbox"/> Pain <input type="checkbox"/> Stress <input type="checkbox"/> Other

(1) Core Visits: The HRIF Clinic has three core visits that take place during the following recommended time periods: **Visit #1** (4-8 months), **Visit #2** (12-16 months) and **Visit #3** (18-36 months). **NOTE:** Core Visit #1 is the initial first visit to the HRIF Clinic, even if the patient is older than 8 months corrected age.

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INTERVAL MEDICAL ASSESSMENT

Does the Child have a Primary Care Provider? No Yes Unknown

Does the Primary Care Provider Act as the Child's Medical Home? No Yes Unknown

Hospitalizations Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Number of Hospitalizations <input type="checkbox"/> Unknown															
	If Yes, Check all that apply															
	Hospitalization Reasons	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Gastrointestinal Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Meningitis Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nutrition/Inadequate Growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Seizure Disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Urinary Tract Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Number of Surgeries <input type="checkbox"/> Unknown															
	If Yes, Check all that apply															
	<input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Inguinal Hernia Repair <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other Gastrointestinal Surgical Procedures <input type="checkbox"/> Other Surgical Procedures	<input type="checkbox"/> Circumcision <input type="checkbox"/> Retinopathy of Prematurity <input type="checkbox"/> Tympanostomy Tubes <input type="checkbox"/> Other Genitourinary Surgical Procedures <input type="checkbox"/> Unknown	<input type="checkbox"/> Gastrostomy Tube Placement <input type="checkbox"/> Shunt/Shunt Revision <input type="checkbox"/> Other ENT Surgical Procedures <input type="checkbox"/> Other Neurosurgical Procedures													

Medications Since Last Visit	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown															
	If Yes, Check all that apply															
	<input type="checkbox"/> Actigall <input type="checkbox"/> Antibiotics/Antifungal <input type="checkbox"/> Cardiac Medications <input type="checkbox"/> Diuretics <input type="checkbox"/> Inhaled Steroids (daily) <input type="checkbox"/> Nutrition Supplements (make selection): <input type="checkbox"/> Oral Steroids <input type="checkbox"/> Oxygen (if discontinued also enter chronologic post-natal age: _____ months _____ days) <input type="checkbox"/> Viagra (Pulmonary Hypertension) <input type="checkbox"/> Unknown	<input type="checkbox"/> Anti Reflux Medication <input type="checkbox"/> Antihypertensive <input type="checkbox"/> Chest Physiotherapy (daily) <input type="checkbox"/> Inhaled Bronchodilators (daily) <input type="checkbox"/> Inhaled Steroids (inter.) <input type="checkbox"/> Enteral Nutrition	<input type="checkbox"/> Anti Seizure Medication <input type="checkbox"/> Caffeine <input type="checkbox"/> Chest Physiotherapy (inter.) <input type="checkbox"/> Inhaled Bronchodilators (inter.) <input type="checkbox"/> Dietary Supplements <input type="checkbox"/> Other													

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INTERVAL MEDICAL ASSESSMENT - continue

	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Equipment Since Last Visit	If Yes, Check all that apply	
	<input type="checkbox"/> Apnea/CR Monitor <input type="checkbox"/> Helmet <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other	<input type="checkbox"/> Braces/Castings/Orthotics <input type="checkbox"/> Nebulizer <input type="checkbox"/> Ventilator/CPAP/BiPAP <input type="checkbox"/> Unknown
	<input type="checkbox"/> Enteral Feeding Equipment <input type="checkbox"/> Ostomy Supplies <input type="checkbox"/> Wheelchair	

MEDICAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Medical Services?

No (Skip to **Neurosensory Assessment**)
 Yes (Complete below)
 Unknown (Skip to **Neurosensory Assessment**)

Audiology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Cardiology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Craniofacial	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Endocrinology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Gastroenterology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Hematology/ Oncology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Metabolic/ Genetics	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Nephrology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason
Neurology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Visit Pending <input type="checkbox"/> Re-Referral <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Service Not Available <input type="checkbox"/> Other/Unknown Reason

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MEDICAL SERVICES REVIEW - <i>continue</i>			
Neurosurgery	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Ophthalmology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Orthopedic	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Otolaryngology (ENT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Pulmonology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Surgery	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available
Urology	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving (check reason)</u> <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Parent Declined/Refused Service <input type="checkbox"/> Other/Unknown Reason	<input type="checkbox"/> Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Not Available

NEUROSENSORY ASSESSMENT

Vision Assessment History

Does the Child Have History of Retinopathy of Prematurity (ROP)? No Yes

Eye Surgery and/or Treatment with Anti-VEGF (i.e. Avastin)? No Yes Scheduled Unknown

Location of ROP: Unilateral Bilateral Unknown

Does the Child Have Visual Impairment?

No (Skip to **Hearing Assessment History**)

Yes **A. Impairment Due To: (check all that apply)**

No, Type of Impairment at Visit

<input type="checkbox"/> Strabismus:	Eye Surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Scheduled
<input type="checkbox"/> Cataract:	Eye Surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Scheduled
<input type="checkbox"/> Retinoblastoma:	Eye Surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Scheduled

Cortical Visual Impairment Refractive Errors
 Nystagmus ROP
 Other Unknown

B. Location of Impairment: Unilateral Bilateral Unknown

C. Corrective Lens(es) Recommended: No Yes Unknown

D. Corrective Lens(es) Used: No Yes Unknown

E. Is There Functional Vision? Yes No (*complete below*)

Location of "Blindness" Unilateral Bilateral Unknown

STANDARD VISIT (SV) FORM

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**Required Field*

NEUROSENSORY ASSESSMENT - continue

Unknown Visual Impairment

Why is Visual Impairment Unknown?

- | | |
|--|---|
| <input type="checkbox"/> Exam Results Unknown | <input type="checkbox"/> No Ophthalmology Exam Performed |
| <input type="checkbox"/> Needs Referral for Exam | <input type="checkbox"/> Referred for Exam, Not Received |
| <input type="checkbox"/> Referred, but Service Not Available | <input type="checkbox"/> Referred, but Parent Declines/Refuses Services |
| <input type="checkbox"/> Referred, but Insurance/HMO Denied Services | <input type="checkbox"/> Referred, but Missed Appointment |
| <input type="checkbox"/> Referred for Functional Vision Assessment | <input type="checkbox"/> Functional Vision Assessment in Progress |

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?

No (Skip to **Neurologic Assessment**)

Yes **A. Is There Loss in One or Both Ears?** One Both Assessment in Progress Unknown

B. Does the Child Use an Assistive Listening Device (ALD):

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, ALD Recommended, but Not Received |
| <input type="checkbox"/> Yes, ALD Recommended and Received | <input type="checkbox"/> Unknown |

C. Type of ALD(s) Used (check all that apply)

- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> BAHA | <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> FM System |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

Unknown Hearing Loss

Why is Hearing Loss Unknown?

- | | |
|--|---|
| <input type="checkbox"/> Exam Results Unknown | <input type="checkbox"/> No Audiology Exam Performed |
| <input type="checkbox"/> Needs Referral for Exam | <input type="checkbox"/> Referred for Exam, Not Received |
| <input type="checkbox"/> Referred, but Service Not Available | <input type="checkbox"/> Referred, but Parent Declines/Refuses Services |
| <input type="checkbox"/> Referred, but Insurance/HMO Denied Services | <input type="checkbox"/> Referred, but Missed Appointment |

Hearing Assessment in Progress (Skip to **Neurologic Assessment**)

NEUROLOGIC ASSESSMENT

***Was a Neurologic Exam Performed During this Core Visit?**

Yes **Date Performed:** - - (MM-DD-YYYY)

No **Reason Why Exam NOT Performed:**

<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Examiner Not Available
<input type="checkbox"/> Known SEVERE Developmental Disability	<input type="checkbox"/> Primary Caregiver Refused	<input type="checkbox"/> Primary Language
<input type="checkbox"/> Significant Sensory Impairment/Loss	<input type="checkbox"/> Other Medical Condition	<input type="checkbox"/> Other

Summary of Neurologic Assessment

Normal (skip to **Developmental Assessment**)

Abnormal

Suspect

A. Oral Motor Function – Age Appropriate Responses for the Following:

- | | | | | |
|---------------------------|---------------------------------|-----------------------------------|----------------------------------|--|
| Feeding: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Swallowing: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Management of Secretions: | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |

B. Muscle Tone

- | | | | | | |
|-------------------|---------------------------------|------------------------------------|------------------------------------|----------------------------------|--|
| Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Trunk | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Right Upper Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Left Upper Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Right Lower Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |
| Left Lower Limb: | <input type="checkbox"/> Normal | <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> Suspect | <input type="checkbox"/> Unable to Determine |

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**Required Field*

NEUROLOGIC ASSESSMENT - continue

C. Is There Scissoring of the Legs on Vertical Suspension? No Yes

D. Deep Tendon Reflexes:

Right Upper Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine	
Left Upper Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine	
Right Lower Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Clonus	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine
Left Lower Limb:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Clonus	<input type="checkbox"/> Suspect	<input type="checkbox"/> Unable to Determine

E. Are Persistent Primitive Reflexes Present? No Yes Unknown

F. Are Abnormal Involuntary Movements Present? No Yes (check all that apply) Unknown

Ataxia Choreoathetoid Tremors

G. Quality of Movement and Posture: Normal Abnormal Suspect Unable to Determine

Functional Assessment

A. Bimanual Function Normal Abnormal Suspect Unable to Determine

Only Complete if the Child is ≥ 15 Months Adjusted Age

B. Right Pincer Grasp Normal Abnormal Suspect Unable to Determine

C. Left Pincer Grasp Normal Abnormal Suspect Unable to Determine

CEREBRAL PALSY (CP)

Does the Child Have Cerebral Palsy (CP)?

No (skip to **Developmental Assessment**)

Yes

Suspect

Gross Motor Function Classification System (GMFCS) Adjusted Age: (check only one)

Child 18 - 24 months of age adjusted for prematurity

Level I Level IV
 Level II Level V
 Level III Unable to Determine

Child ≥ 24 - 36 months of age adjusted for prematurity

Level I Level IV
 Level II Level V
 Level III Unable to Determine

Unable to Determine

DEVELOPMENTAL CORE VISIT ASSESSMENT

***Was a Developmental Assessment Screener or Test Performed During this Core Visit?**

Yes **Date Performed:** - - (MM-DD-YYYY)

No Reason Why Assessment **NOT** Performed:

<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Examiner Not Available
<input type="checkbox"/> Known SEVERE Developmental Disability	<input type="checkbox"/> Primary Caregiver Refused	<input type="checkbox"/> Primary Language
<input type="checkbox"/> Significant Sensory Impairment/Loss	<input type="checkbox"/> Other Medical Condition	<input type="checkbox"/> Other

DEVELOPMENTAL SCREENERS

Bayley Infant Neurodevelopmental Screener (BINS) – check appropriate range

Overall Classification: Low Risk Medium Risk High Risk Unable to Assess

Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - check appropriate range

Adaptive Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive Domain:	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

STANDARD VISIT (SV) FORM

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DEVELOPMENTAL SCREENERS - *continue*

Bayley Scales of Infant and Toddler Development Screening Test, 3rd Edition (Bayley-III Scener) - check appropriate range					
Cognitive:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Competent	<input type="checkbox"/> Emerging	<input type="checkbox"/> At Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) - enter score					
Language Auditory (CLAMS)	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Cognitive Adaptive (CAT)	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Full Scale Capute	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Other/Not Listed Screener: _____ - check appropriate range					
Cognitive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Other:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Hardcopy" - enter score			
Cognitive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive-Behavior Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Computer" - enter score			
Receptive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor Scaled Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

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DEVELOPMENTAL TESTS – *continue*

Battelle Developmental Inventory, 2nd Edition (BDI-2) - enter score					
Adaptive Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Personal-Social Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Receptive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Expressive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Communication Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Gross Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Motor Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Cognitive Domain	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell) - enter score					
Language Development	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Gross Motor	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Personal-Social	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Adaptive	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Mullen Scales of Early Learning - AGS Edition (Mullen) - enter score					
Gross Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Visual Perception	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Fine Motor Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Receptive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Expressive Language Scale	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Early Learning Composite	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess		
Other/Not Listed Test: _____ - check appropriate range					
Cognitive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Composite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Other:	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Significant	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
AUTISM SPECTRUM SCREEN (Optional)					
Was an Autism Spectrum Screen Performed During this Visit?		<input type="checkbox"/> No	<input type="checkbox"/> Yes (complete below)		
Screening Tool Used:	<input type="checkbox"/> M-CHAT	<input type="checkbox"/> CSBS-DP	<input type="checkbox"/> PDDST-II	<input type="checkbox"/> Other/Not Listed	
Screening Results:	<input type="checkbox"/> Pass	<input type="checkbox"/> Did Not Pass			
Was the Infant Referred for Further Autism Spectrum Assessment?		<input type="checkbox"/> No	<input type="checkbox"/> Yes		

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EARLY START (ES) PROGRAM

Is the Child Currently Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? (check only one)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No, Not Required | <input type="checkbox"/> No, Referred at Visit | <input type="checkbox"/> No, Referral Failure |
| <input type="checkbox"/> No, Pending Services | <input type="checkbox"/> No, Parent Refused Service | <input type="checkbox"/> No, Determined Ineligible by ES | <input type="checkbox"/> Unknown |

MEDICAL THERAPY PROGRAM (MTP)

Is the Child Currently Receiving Services Through CCS Medical Therapy Program (MTP)? (check only one)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No, Not Required | <input type="checkbox"/> No, Referred at Visit | <input type="checkbox"/> No, Referral Failure |
| <input type="checkbox"/> No, Pending Services | <input type="checkbox"/> No, Parent Refused Service | <input type="checkbox"/> No, Determined Ineligible by ES | <input type="checkbox"/> Unknown |

SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?

- No (Skip to Resources and Social Concerns) Yes (Complete below) Unknown

Behavior Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Other	<input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Unknown	<input type="checkbox"/> Psychologist
Feeding Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Other	<input type="checkbox"/> Certified Lactation Consultant <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Unknown	<input type="checkbox"/> Home Health Agency <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Speech/Language Pathologist
Infant Development Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> MSW <input type="checkbox"/> Unknown	<input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech/Language Pathologist	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other
Hearing Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Audiologist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Unknown	<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Teacher of the Deaf	<input type="checkbox"/> ENT <input type="checkbox"/> Other
Nutritional Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	<u>Referred, but Not Receiving</u> (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referred <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider:		
	<input type="checkbox"/> Certified Lactation Consultant <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Unknown	<input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Physician <input type="checkbox"/> Other

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SPECIAL SERVICES REVIEW - continue			
Occupational Therapy (OT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Physical Therapy (PT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Speech/Language Communication	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> American Sign Language <input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Teacher of the Deaf <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Social Work Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Physician <input type="checkbox"/> MSW <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Visiting, Public Health, and/or Home Nursing	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> Licensed Vocational Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Vision Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Complete <input type="checkbox"/> Referred at Time of Visit	Referred, but Not Receiving (check reason) <input type="checkbox"/> Missed Appointment <input type="checkbox"/> Re-Referral <input type="checkbox"/> Service Not Available <input type="checkbox"/> Parent Declined/Refused Service	<input type="checkbox"/> Waiting List / Visit Pending <input type="checkbox"/> Insurance/HMO Denied <input type="checkbox"/> Service Cancelled <input type="checkbox"/> Other/Unknown Reason
	Service Provider: <input type="checkbox"/> Low Vision Specialist (Optometrist) <input type="checkbox"/> Low Vision Specialist (Ophthalmologist) <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Orientation & Mobility Specialist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Teacher of the Visually Impaired <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

