STANDARD VISIT (SV) FORM

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

Required Field

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

***This visit was conducted:**	☐ In-person	☐ Telehealth (audio + video observation)	☐ Phone Only

VISIT ASSESSMENT

***Core Visit** (1)	☐ #1 (4-8 months)	☐ #2 (12-16 months)	☐ #3 (18-36 months)
Zip Code of Primary Caregiver: ☐☐☐☐☐			
Chronological Age: ☐☐ Months ☐☐ Days		**Adjusted Age:** ☐☐ Months ☐☐ Days	

Interpreter Used				
	☐ **No**			
	☐ **Yes:**	☐ Spanish	☐ Arabic	☐ Armenian
		☐ Cambodian/Khmer	☐ Cantonese	☐ Farsi/Persian
		☐ Hmong/Miao	☐ Korean	☐ Mandarin
		☐ Russian	☐ Sign Language	☐ Tagalog
		☐ Vietnamese	☐ Other	☐ Unknown
		☐ Declined		

Insurance (Check all that apply)

☐ CCS	☐ Commercial HMO	☐ Commercial PPO	☐ Medi-Cal
☐ Point of Service/EPO	☐ No Insurance/Self Pay	☐ Other	☐ Unknown

PATIENT ASSESSMENT

Weight	**Length**	**Head Circumference**
☐☐.☐☐ (kg)	☐☐☐.☐ (cm)	☐☐☐.☐ (cm)
or ☐☐ (lbs) ☐☐ (oz)	or ☐☐.☐☐ (in)	or ☐☐.☐☐ (in)
Reason NOT Collected: ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other	**Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other	**Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other

GENERAL ASSESSMENT

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

HRIF HIGH RISK INFANT FOLLOW-UP cpqcc

STANDARD VISIT (SV) FORM

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

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

☐ **No** ☐ **Yes:** ☐☐ Number of Hospitalizations ☐ **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)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meningitis Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nutrition/Inadequate Growth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Tract Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Rehospitalization(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having Surgeries During Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Surgeries Since Last Visit

☐ **No** ☐ **Yes:** ☐☐ Number of Surgeries ☐ **Unknown**

If Yes, Check all that apply

- ☐ Cardiac Surgery
- ☐ Inguinal Hernia Repair
- ☐ Tracheostomy
- ☐ Other Gastrointestinal Surgical Procedures
- ☐ Other Surgical Procedures
- ☐ Circumcision
- ☐ Retinopathy of Prematurity
- ☐ Tympanostomy Tubes
- ☐ Other Genitourinary Surgical Procedures
- ☐ Unknown
- ☐ Gastrostomy Tube Placement
- ☐ Shunt/Shunt Revision
- ☐ Other ENT Surgical Procedures
- ☐ Other Neurosurgical Procedures

Medications Since Last Visit

☐ **No** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply

- ☐ Actigall
- ☐ Antibiotics/Antifungal
- ☐ Cardiac Medications
- ☐ Diuretics
- ☐ Inhaled Steroids (daily)
- ☐ Anti-Reflux Medication
- ☐ Antihypertensive
- ☐ Chest Physiotherapy (daily)
- ☐ Inhaled Bronchodilators (daily)
- ☐ Inhaled Steroids (inter.)
- ☐ Anti-Seizure Medication
- ☐ Caffeine
- ☐ Chest Physiotherapy (inter.)
- ☐ Inhaled Bronchodilators (inter.)
- ☐ Nutrition Supplements (make selection): ☐ Enteral Nutrition ☐ Dietary Supplements
- ☐ Oral Steroids
- ☐ Oxygen (if discontinued also enter chronologic post-natal age: __________ months __________ days)
- ☐ Viagra (Pulmonary Hypertension)
- ☐ Synagis / Palivizumab
- ☐ Other
- ☐ Unknown

Equipment Since Last Visit

☐ **No** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply

- ☐ Apnea/CR Monitor
- ☐ Helmet
- ☐ Tracheostomy
- ☐ Other
- ☐ Braces/Castings/Orthotics
- ☐ Nebulizer
- ☐ Ventilator/CPAP/BiPAP
- ☐ Unknown
- ☐ Enteral Feeding Equipment
- ☐ Ostomy Supplies
- ☐ Wheelchair

STANDARD VISIT (SV) FORM

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

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**)

Service	Status	Referred, but Not Receiving (check reason)
Allergy / Immunology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Audiology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Cardiology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Craniofacial	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Endocrinology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Gastroenterology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Hematology / Oncology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Metabolic / Genetics	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Nephrology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurosurgery	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason ☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

STANDARD VISIT (SV) FORM

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

MEDICAL SERVICES REVIEW - *continue*

Service	Status	Referred, but Not Receiving (check reason)	
Ophthalmology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Orthopedic	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Otolaryngology (ENT)	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Pulmonology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Surgery	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Urology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ 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

Impairment				
☐ Strabismus:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Cataract:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Retinoblastoma:	Eye Surgery?	☐ No	☐ Yes	☐ 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

HRIF HIGH RISK INFANT FOLLOW-UP cpqcc

STANDARD VISIT (SV) FORM

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Required Field

NEUROSENSORY ASSESSMENT - *continue*

☐ **Unknown Visual Impairment**

Why is Visual Impairment Unknown?

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but Insurance/HMO Denied Services
- ☐ Referred for Functional Vision Assessment
- ☐ No Ophthalmology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ Referred, but Missed Appointment
- ☐ 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):

- ☐ No
- ☐ Yes, ALD Recommended and Received
- ☐ Yes, ALD Recommended, but Not Received
- ☐ Unknown

C. Type of ALD(s) Used (check all that apply) ☐ BAHA ☐ Hearing Aid ☐ Cochlear Implant ☐ Other ☐ FM System ☐ Unknown

☐ **Unknown Hearing Loss**

Why is Hearing Loss Unknown?

- ☐ Exam Results Unknown
- ☐ Needs Referral for Exam
- ☐ Referred, but Service Not Available
- ☐ Referred, but Insurance/HMO Denied Services
- ☐ No Audiology Exam Performed
- ☐ Referred for Exam, Not Received
- ☐ Referred, but Parent Declines/Refuses Services
- ☐ 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:**

- ☐ Acute Illness
- ☐ Known SEVERE Developmental Disability
- ☐ Significant Sensory Impairment/Loss
- ☐ Behavior Problems
- ☐ Primary Caregiver Refused
- ☐ Other Medical Condition
- ☐ Examiner Not Available
- ☐ Primary Language
- ☐ Other

***This Part of the Visit was Done by:** ☐ In-person ☐ Telehealth (audio + video observation) ☐ Phone Only

Summary of Neurologic Assessment

☐ **Normal** (skip to **Developmental Assessment**)

☐ **Abnormal**

☐ **Suspect**

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

Feeding:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Swallowing:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Management of Secretions:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine

B. Muscle Tone

Neck	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Trunk	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ 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:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ 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		*Child ≥ 24 - 36 months of age adjusted for prematurity*	
☐ Level I	☐ Level IV	☐ Level I	☐ Level IV
☐ Level II	☐ Level V	☐ Level II	☐ Level V
☐ Level III	☐ Unable to Determine	☐ 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:

☐ Acute Illness	☐ Behavior Problems	☐ Examiner Not Available
☐ Known SEVERE Developmental Disability	☐ Primary Caregiver Refused	☐ Primary Language
☐ Significant Sensory Impairment/Loss	☐ Other Medical Condition	☐ Other

***This Part of the Visit was Done by:** ☐ In-person ☐ Telehealth (audio + video observation) ☐ Phone Only

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:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Communication:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Motor Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

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

DEVELOPMENTAL SCREENERS - *continue*

Bayley Scales of Infant and Toddler Development Screener III (Bayley-III) - *check appropriate range*					
Cognitive:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development Screener 4 (Bayley 4) - *check appropriate range*					
Cognitive:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ 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: ______	☐ Unable to Assess	☐ Did Not Assess
Cognitive Adaptive (CAT)	Score: ______	☐ Unable to Assess	☐ Did Not Assess
Full Scale Capute	Score: ______	☐ Unable to Assess	☐ Did Not Assess

Warner Initial Developmental Evaluation of Adaptive and Functional Skills (WIDEA-FS) - *enter score*			
Self-Care	Score: ______	☐ Unable to Assess	☐ Did Not Assess
Mobility	Score: ______	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: ______	☐ Unable to Assess	☐ Did Not Assess
Social Cognition	Score: ______	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Screener: ____________________________________ – *check appropriate range*					
Cognitive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development (Bayley-III) "Hardcopy" - *enter score*			
Cognitive Composite	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scaled Score	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional Composite	Score: _______	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior Composite	Score: _______	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

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DEVELOPMENTAL TESTS - *continue*

Bayley Scales of Infant and Toddler Development (Bayley-III) "Computer" - *enter score*			
Receptive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "Hardcopy" - *enter score*			
Cognitive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "Computer" - *enter score*			
Receptive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Battelle Developmental Inventory, 2nd Edition (BDI-2) - *enter score*			
Adaptive Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Communication Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell) - *enter score*			
Language Development	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive	Score: ________	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

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

DEVELOPMENTAL TESTS - *continue*

Mullen Scales of Early Learning - AGS Edition (Mullen) - *enter score*			
Gross Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Visual Perception	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Early Learning Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

The Developmental Assessment of Young Children 2nd Edition (DAYC-2) - *enter score*			
Cognitive	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Physical Development	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Developmental Profile 3 (DP-3) - *enter score*			
Physical	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Developmental Profile 4 (DP-4) - *enter score*			
Physical	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Test:____________________ - *check appropriate range*					
Cognitive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

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

AUTISM SPECTRUM SCREEN (Optional)

Was an Autism Spectrum Screen Performed During this Visit? ☐ **No** ☐ **Yes** *(complete below)*

Screening Tool Used: ☐ M-CHAT ☐ CSBS-DP ☐ PDDST-II ☐ Other/Not Listed

Screening Results: ☐ Pass ☐ Did Not Pass

Was the Infant Referred for Further Autism Spectrum Assessment? ☐ **No** ☐ **Yes**

EARLY START (ES) PROGRAM

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

☐ **Yes**	☐ **No, Not Required**	☐ **No, Referred at Visit**	☐ **No, Referral Failure**
☐ **No, Pending Services**	☐ **No, Parent Refused Service**	☐ **No, Determined Ineligible by ES**	☐ **Unknown**

MEDICAL THERAPY PROGRAM (MTP)

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

☐ **Yes**	☐ **No, Not Required**	☐ **No, Referred at Visit**	☐ **No, Referral Failure**
☐ **No, Pending Services**	☐ **No, Parent Refused Service**	☐ **No, Determined Ineligible by ES**	☐ **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**

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

STANDARD VISIT (SV) FORM

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

SPECIAL SERVICES REVIEW – *continue*			
Nutritional Therapy	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Certified Lactation Consultant ☐ Registered Dietitian ☐ Unknown	 ☐ Public Health Nurse ☐ Registered Nurse	 ☐ Physician ☐ Other
Occupational Therapy (OT)	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Occupational Therapist	 ☐ Other	 ☐ Unknown
Physical Therapy (PT)	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Physical Therapist	 ☐ Other	 ☐ Unknown
Speech / Language Communication	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ American Sign Language ☐ Speech/Language Pathologist	 ☐ Early Intervention Specialist ☐ Other	 ☐ Teacher of the Deaf ☐ Unknown
Social Work Intervention	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Clinical Social Worker ☐ Physician ☐ Unknown	 ☐ Marriage & Family Therapist ☐ MSW	 ☐ Psychologist ☐ Other
Visiting, Public Health, and /or Home Nursing	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	 ☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Vocational Nurse ☐ Registered Nurse	 ☐ Physician ☐ Other	 ☐ Public Health Nurse ☐ Unknown

STANDARD VISIT (SV) FORM

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SPECIAL SERVICES REVIEW – *continue*

Vision Services		
Vision Services	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Waiting List / Visit Pending ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Service Not Available ☐ Service Cancelled ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason
	Service Provider: ☐ Low Vision Specialist (Optometrist) ☐ Low Vision Specialist (Ophthalmologist) ☐ Occupational Therapist ☐ Orientation & Mobility Specialist ☐ Physical Therapist ☐ Teacher of the Visually Impaired ☐ Other ☐ Unknown	

SOCIAL CONCERNS AND RESOURCES

Concern	No	Yes
Caregiver-Child Disruptions or Concerns *Single parent, divorce, prolonged separation (incarceration, military service) multiple changes in caregivers/daycare, caregiver chronic illness*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Economic/Environmental Concerns/Stressors *Housing insecurity, lack of resources-$$, insurance (or high co-pay), lack of reliable transportation for medical needs*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Community & Relationship Concerns *Emotional support from family/friends, supportive and safe intimate relationship, safe neighborhood, and resources for needs*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Parent-Child Concerns *Feeding & growth, calming, behavior, sleep, other*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Food Insecurity *Lack of resources$$ to purchase food, not enough food to feed the family*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources

CHILD PROTECTIVE SERVICES (CPS)

Is a Child Protective Services Case Currently Opened?

☐ **No** ☐ **Yes** ☐ **Referred at Time of Visit**

OTHER MEDICAL CONDITIONS

Question			
Has the Child Been Tested for COVID-19?	☐ **No**	☐ **Yes**	☐ **Unknown**
Has the Child's Immunization Schedule Ever Been Delayed?	☐ **No**	☐ **Yes** *(complete below)*	☐ **Unknown**
Was the Delay Due to the COVID-19 Pandemic?	☐ No	☐ Yes	

Were there Additional Medical Conditions Identified that may Impact the Child's Outcome? ☐ **No** ☐ **Yes** (complete below)
(check all categories that apply and provide a description of the diagnosis)

☐ **Cardiovascular and Circulatory:**

☐ **Endocrine and Metabolic:**

☐ **Eye, Ear, Nose:**

☐ **Gastrointestinal and Hepatobiliary:**

☐ **Genetic:**

☐ **Hematologic, Immunologic, or Oncologic/Neoplasm:**

☐ **Infectious Diseases:**

☐ **Injuries, Accident, Poisoning:**

☐ **Renal and Genitourinary Tract:**

☐ **Respiratory System:**

☐ **Nervous System:**

☐ **Other:**

STANDARD VISIT (SV) FORM

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

***Required Field**

DISPOSITION** ***(Required Field)	
☐ Scheduled to Return	☐ Will be Followed by Another CCS HRIF Clinic (1)
☐ Completed HRIF Core Visits, Scheduled to Return	
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

(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"***.