

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:

<input type="checkbox"/> Spanish	<input type="checkbox"/> Arabic	<input type="checkbox"/> Armenian
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Farsi/Persian	<input type="checkbox"/> Hindi
<input type="checkbox"/> Hmong/Miao	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean
<input type="checkbox"/> Mandarin	<input type="checkbox"/> Mixteco	<input type="checkbox"/> Mon-Khmer/Cambodian
<input type="checkbox"/> Punjabi	<input type="checkbox"/> Russian	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Tagalog	<input type="checkbox"/> Thai	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Other: _____		

Insurance (Check all that apply)

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

PATIENT ASSESSMENT

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

<p>Is the Child Currently Receiving Breastmilk?</p> <p><input type="checkbox"/> Exclusively <input type="checkbox"/> Some <input type="checkbox"/> None</p>	<p>Living Arrangement of the Child</p> <p><input type="checkbox"/> Both Parents <input type="checkbox"/> One Parent <input type="checkbox"/> One Parent/Other Relatives <input type="checkbox"/> Other Relatives/Not Parents <input type="checkbox"/> Non Relative <input type="checkbox"/> Foster/Adoptive Family <input type="checkbox"/> Foster Family/CPS <input type="checkbox"/> Pediatric Subacute Facility <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>															
<p>Education of Primary Caregiver</p> <p><input type="checkbox"/> <9th 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</p>	<p>Caregiver Employment</p> <p><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</p>															
<p>Routine Child Care</p> <p><input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>If Yes, Check all that apply:</p> <p><input type="checkbox"/> Child Care Outside of Home <input type="checkbox"/> Home Babysitter/Nanny <input type="checkbox"/> Not Used Routinely <input type="checkbox"/> Specialized Medical Setting <input type="checkbox"/> Other</p>	<p>Caregiver Concerns of the Child</p> <p><input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>If Yes, Check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Behavioral</td> <td><input type="checkbox"/> Calming/Crying</td> <td><input type="checkbox"/> Feeding & Growth</td> </tr> <tr> <td><input type="checkbox"/> Frequent Illness</td> <td><input type="checkbox"/> Gastrointestinal/Stooling/Spitting-up</td> <td><input type="checkbox"/> Hearing</td> </tr> <tr> <td><input type="checkbox"/> Medications</td> <td><input type="checkbox"/> Motor Skills, Movement</td> <td><input type="checkbox"/> Pain</td> </tr> <tr> <td><input type="checkbox"/> Sensory Processing</td> <td><input type="checkbox"/> Speech & Language</td> <td><input type="checkbox"/> Stress</td> </tr> <tr> <td><input type="checkbox"/> Sleeping/Napping</td> <td><input type="checkbox"/> Vision</td> <td><input type="checkbox"/> Other</td> </tr> </table>	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Calming/Crying	<input type="checkbox"/> Feeding & Growth	<input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Gastrointestinal/Stooling/Spitting-up	<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications	<input type="checkbox"/> Motor Skills, Movement	<input type="checkbox"/> Pain	<input type="checkbox"/> Sensory Processing	<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Stress	<input type="checkbox"/> Sleeping/Napping	<input type="checkbox"/> Vision	<input type="checkbox"/> Other
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Calming/Crying	<input type="checkbox"/> Feeding & Growth														
<input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Gastrointestinal/Stooling/Spitting-up	<input type="checkbox"/> Hearing														
<input type="checkbox"/> Medications	<input type="checkbox"/> Motor Skills, Movement	<input type="checkbox"/> Pain														
<input type="checkbox"/> Sensory Processing	<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Stress														
<input type="checkbox"/> Sleeping/Napping	<input type="checkbox"/> Vision	<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

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

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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**)

Allergy / Immunology	<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-Referred <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
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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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
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"/> Visit Pending <input type="checkbox"/> Re-Referred <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

STANDARD VISIT (SV) FORM

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MEDICAL SERVICES REVIEW - continue

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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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-Referred <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

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

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

***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: | <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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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

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

DEVELOPMENTAL SCREENERS

Ages and Stages Questionnaire 3rd Edition (ASQ-3) - check appropriate scoring zone

Communication	<input type="checkbox"/> On Schedule	<input type="checkbox"/> Monitor	<input type="checkbox"/> Below	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor	<input type="checkbox"/> On Schedule	<input type="checkbox"/> Monitor	<input type="checkbox"/> Below	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor	<input type="checkbox"/> On Schedule	<input type="checkbox"/> Monitor	<input type="checkbox"/> Below	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Problem-Solving	<input type="checkbox"/> On Schedule	<input type="checkbox"/> Monitor	<input type="checkbox"/> Below	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social	<input type="checkbox"/> On Schedule	<input type="checkbox"/> Monitor	<input type="checkbox"/> Below	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

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



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

DEVELOPMENTAL SCREENERS - *continue*

Bayley Scales of Infant and Toddler Development Screener III (Bayley-III) - *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

Bayley Scales of Infant and Toddler Development Screener 4 (Bayley 4) - *check appropriate range*

Cognitive:	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Borderline Risk	<input type="checkbox"/> High Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Receptive Language:	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Borderline Risk	<input type="checkbox"/> High Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Expressive Language:	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Borderline Risk	<input type="checkbox"/> High Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Fine Motor:	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Borderline Risk	<input type="checkbox"/> High Risk	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Gross Motor:	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Borderline Risk	<input type="checkbox"/> High 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

Warner Initial Developmental Evaluation of Adaptive and Functional Skills (WIDEA-FS) - *enter score*

Self-Care	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Mobility	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social Cognition	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 (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

STANDARD VISIT (SV) FORM



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

DEVELOPMENTAL TESTS - *continue*

Bayley Scales of Infant and Toddler Development (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

Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "Hardcopy" - *enter score*

Cognitive Standard Score	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 Standard 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
Motor Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive-Behavior Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "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 Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Language Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Motor Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Personal-Social Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Standard Score	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

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

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: _____	<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

The Developmental Assessment of Young Children 2nd Edition (DAYC-2) - *enter score*

Cognitive	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Physical Development	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Behavior	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

Developmental Profile 3 (DP-3) - *enter score*

Physical	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Behavior	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess

Developmental Profile 4 (DP-4) - *enter score*

Physical	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Adaptive Behavior	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Social-Emotional	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Cognitive	Score: _____	<input type="checkbox"/> Unable to Assess	<input type="checkbox"/> Did Not Assess
Communication	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

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:	<input type="checkbox"/> M-CHAT-RF	Screening Results:	<input type="checkbox"/> Pass	M-CHAT-RF Risk Level:	<input type="checkbox"/> Low Risk
	<input type="checkbox"/> CSBS-DP		<input type="checkbox"/> Did Not Pass		<input type="checkbox"/> Medium Risk
	<input type="checkbox"/> Other/Not Listed				<input type="checkbox"/> High Risk

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, Complete
 No, Not Required
 No, Referred at Visit
 No, Referral Failure
 No, Pending Services
 No, Parent Refused
 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, Complete
 No, Not Required
 No, Referred at Visit
 No, Referral Failure
 No, Pending Services
 No, Parent Refused
 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

Behavior Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> Early Intervention Specialist <input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

Feeding Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> Early Intervention Specialist <input type="checkbox"/> Certified Lactation Consultant <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

Infant Development Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> Early Intervention Specialist <input type="checkbox"/> Licensed Clinical Social Worker <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> MSW <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

Hearing Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> Audiologist <input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> ENT <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Teacher of the Deaf <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

STANDARD VISIT (SV) FORM



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

SPECIAL SERVICES REVIEW – continue

Nutritional Therapy	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> 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
Occupational Therapy (OT)	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> 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"/> Receiving - Increase Frequency <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"/> 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"/> Receiving - Increase Frequency <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"/> 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"/> Speech/Language Pathologist		<input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Other	<input type="checkbox"/> Teacher of the Deaf <input type="checkbox"/> Unknown
Social Work Intervention	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> 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"/> Physician <input type="checkbox"/> Unknown		<input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> MSW	<input type="checkbox"/> Psychologist <input type="checkbox"/> Other
Visiting, Public Health, and/or Home Nursing	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> 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"/> Registered Nurse		<input type="checkbox"/> Physician <input type="checkbox"/> Other	<input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Unknown

STANDARD VISIT (SV) FORM



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

SPECIAL SERVICES REVIEW – continue

Vision Services	<input type="checkbox"/> Does Not Need <input type="checkbox"/> Receiving <input type="checkbox"/> Receiving - Increase Frequency <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"/> Orientation & Mobility Specialist <input type="checkbox"/> Other		

SOCIAL CONCERNS AND RESOURCES

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

Has the Child Been Tested for COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Has the Child's Immunization Schedule Ever Been Delayed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (complete below)	<input type="checkbox"/> Unknown
Was the Delay Due to the COVID-19 Pandemic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Were there Additional Medical Conditions Identified that may Impact the Child's Outcome?			<input type="checkbox"/> No <input type="checkbox"/> Yes (complete below)
<i>(check all categories that apply and provide a description of the diagnosis)</i>			
<input type="checkbox"/> Cardiovascular and Circulatory:			
<input type="checkbox"/> Endocrine and Metabolic:			
<input type="checkbox"/> Eye, Ear, Nose:			
<input type="checkbox"/> Gastrointestinal and Hepatobiliary:			
<input type="checkbox"/> Genetic:			
<input type="checkbox"/> Hematologic, Immunologic, or Oncologic/Neoplasm:			
<input type="checkbox"/> Infectious Diseases:			
<input type="checkbox"/> Injuries, Accident, Poisoning:			
<input type="checkbox"/> Renal and Genitourinary Tract:			
<input type="checkbox"/> Respiratory System:			
<input type="checkbox"/> Nervous System:			
<input type="checkbox"/> Other:			

STANDARD VISIT (SV) FORM



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

**Required Field*

DISPOSITION (Required Field)

- | | |
|--|--|
| <input type="checkbox"/> Scheduled to Return | <input type="checkbox"/> Will be Followed by Another CCS HRIF Clinic (1) |
| <input type="checkbox"/> Completed HRIF Core Visits, Scheduled to Return | |

DISCHARGED:

- | | |
|---|--|
| <input type="checkbox"/> Graduated | <input type="checkbox"/> Closed Out of Program |
| <input type="checkbox"/> Family Moving Out of State/Country | <input type="checkbox"/> Family Withdrew Prior To Completion |
| <input type="checkbox"/> Will be Followed Elsewhere | <input type="checkbox"/> 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".