Child Health and Disability Prevention Program
Care Coordination / Follow-up Form

Patient Name (Last)	(First)	(Initial)	Language	Date of Service Month Day Year

Birthdate Month Day Year	Age	Sex	Gender	Patient's County of Residence	Telephone # (Home or Cell) ( )	Alternate Phone # (Work or Other) ( )

Responsible Person (Name)	(Street)	(Apt/Space #)	(City)	(Zip)

Patient Eligibility	County	Aid Code	Identification Number	Next CHDP Exam Date: Month Day Year

Ethnic Code ☐

1. White
2. Hispanic/Latino
3. Black/African American
4. American Indian/Alaska Native
5. Asian
6. Native Hawaiian/Other Pacific Islander
7. Other

A. Medical Assessment and Referral Section

☐**No Medical Problems Suspected**

Significant Medical History or Special Conditions: ☐No ☐ Yes, Specify: ____________________

			Comments:
Physical Exam	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled	
Developmental Screening	☐Speech Delay ☐Social/Emotional ☐Cognitive ☐Fine Motor Delay ☐Gross Motor Delay ☐Other	Referred To & Contact # Or ☐Return Visit Scheduled	
Vision Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other: ____________	Referred To & Contact # Or ☐Return Visit Scheduled	
Hearing Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other: ____________	Referred To & Contact # Or ☐Return Visit Scheduled	

B. Dental Assessment and Referral Section

☐**Class I:** No Visible Problems	☐**Class II:** Visible decay, small carious lesion or gingivitis	☐**Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis	☐**Class IV: Emergent** – acute injury, oral infection or other pain
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)	Needs non-urgent dental care	Immediate treatment for urgent dental condition which can progress rapidly	Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: ____________________

☐**Dental home referral** | **Referred To and Contact Number:** ____________________

C. Referring Provider Information

Service Location: Office Name, Address, Telephone Number	Provider Office NPI Number
	Rendering Provider Name (Print Name)
	Provider Signature
	Date

Revised 09/2017