

CLAIM CONTROL NUMBER \* FOR STATE USE ONLY

8  
STAPLE  
HERE

DO NOT STAPLE  
IN BAR AREA

PLEASE PRINT	PATIENT NAME (LAST)	(FIRST)	(INITIAL)	MEDICAL RECORD NO.	LA Code	94	XXXXXXXX	J
	BIRTH DATE (Mo./Day/Year)	AGE	SEX	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM (Mo./Day/Year)	Cethnic Code
	RESPONSIBLE PERSON (NAME)	(STREET)	(APT./SUITE #)	(CITY)	(ZIP)			1 American Indian 2 Asian 3 Black 4 Filipino 5 Mex. Amer./Hispanic 6 White 7 Other 8 Pacific Islander

<b>CHDP ASSESSMENT</b> Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED	REFUSED, CONTRA INDICATED, NOT NEEDED	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column	DATE OF SERVICE (Mo./Day/Year)	FOLLOW UP CODES 1. NO DX/RX INDICATED OR NOW UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK SCHEDULED. 3. DX MADE AND RX STARTED 4. DX PENDING/RETURN VISIT SCHEDULED. 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED
	✓ A	✓ B	INLW C KNOWN D	FEES	

01 HISTORY and PHYSICAL EXAM	A				01
02 DENTAL ASSESSMENT/REHARR					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE (PARENT EDUCATION)					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					

REFERRED TO:	TELEPHONE NUMBER
REFERRED TO:	TELEPHONE NUMBER

**COMMENTS/PROBLEMS**

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS
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HEIGHT IN INCHES	WEIGHT LBS	BODY MASS INDEX (BMI) PP-RD-N II F	BLOOD PRESSURE
0	4		
HEMOCHEMISTRY	HEMOCHEMISTRY	BIRTH WEIGHT LBS	

ROUTINE REFERRAL(S) (✓)	PATIENT IS A FOSTER CHILD (✓)
ROUTINE ( )	DIAGNOSIS

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES		GIVEN TODAY	NOT GIVEN TODAY
NOW UP TO DATE FOR AGE A	STILL NOT UP TO DATE FOR AGE B	ALREADY UP TO DATE FOR AGE C	REFUSED OR CONTRA INDICATED D

DIAGNOSIS CODES	1	2
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PATIENT VISIT (✓)	TYPIC OF SCREEN (✓)	TOTAL FEES
New Patient or Follow-up Visit	Initial Periodic	

**THE QUESTIONS BELOW MUST BE ANSWERED**

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes  No

2. Tobacco Used by Patient. Yes  No

3. Counselor About/Referred For Tobacco Use Prevention Cessation. For Yes  No

**SERVICE LOCATION:** Name, Address, Telephone Number (Please include Area Code)

PROVIDER NUMBER

PLACE OF SERVICE

Enrolled in WIC  Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

PARTIAL SCREEN  SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY

COUNTY AID IDENTIFICATION NUMBER

If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter Billing Number

Patient eligible for CHDP benefits only.

SIGNATURE OF PROVIDER

DATE

PATIENT ELIGIBILITY

COUNTY AID IDENTIFICATION NUMBER

If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter Billing Number

Patient eligible for CHDP benefits only.

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

<u>POS Code</u>	<u>Description</u>
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

**RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:**

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services  
Department of Health Care Services  
MS 8100  
1515 K Street, Suite 400  
Sacramento, CA 95814

(916) 327-1400