

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT STAPLE  
IN BAR AREA

STAPLE  
HERE

P L E A S E  P R I N T	PATIENT NAME (LAST)		(FIRST)		(INITIAL)	MEDICAL RECORD NO.		LA Code	
	Mo.	BIRTHDATE Day	AGE	SEX	M/F	PATIENT'S COUNTY OF RESIDENCE		CO. CODE	TELEPHONE NUMBER
	RESPONSIBLE PERSON (NAME)		(STREET)		(APT./SPACE #)	(CITY)		(ZIP)	NEXT CHDP EXAM Mo. Day Year
Ethnic Code <input type="checkbox"/> 1-American Indian <input type="checkbox"/> 2-Asian <input type="checkbox"/> 3-Black <input type="checkbox"/> 4-Filipino <input type="checkbox"/> 5-Mex./Arner./Hispanic <input type="checkbox"/> 6-White <input type="checkbox"/> 7-Other <input type="checkbox"/> 8-Pacific Islander									

<b>CHDP ASSESSMENT</b> Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE Mo. Day Year		<b>FOLLOW UP CODES</b> 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
			NEW C	KNOWN D	FEES		

01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH 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
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**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

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
0	4			
HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS
		.0%		

**INFORMATION ONLY REPORTING**

ROUTINE REFERRAL(S) (✓)	PATIENT IS A FOSTER CHILD (✓)
BLOOD LEAD <input type="checkbox"/>	DENTAL <input type="checkbox"/>

<b>IMMUNIZATIONS</b> 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

**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. Counseled About/Referred For Tobacco Use Prevention/Cessation. Yes  No

PATIENT VISIT (✓)	TYPE OF SCREEN (✓)	TOTAL FEES
<input type="checkbox"/> 1 New Patient or Extended Visit	<input type="checkbox"/> 1 Initial	
<input type="checkbox"/> 2 Routine Visit	<input type="checkbox"/> 2 Periodic	

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)	HEALTH PLAN CODE/PROVIDER NUMBER	PLACE OF SERVICE

<input type="checkbox"/> 1 Enrolled in WIC	<input type="checkbox"/> 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit	
<input type="checkbox"/> 1 PARTIAL SCREEN	<input type="checkbox"/> 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED
PATIENT ELIGIBILITY
COUNTY
AID
IDENTIFICATION NUMBER


RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER \_\_\_\_\_ DATE \_\_\_\_\_

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM  
Medi-Cal/CHDP  
P.O. Box 15300  
Sacramento, CA 95851-1300

**CONFIDENTIAL SCREENING/BILLING REPORT**

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