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

SUBMIT

Submit to the County CHDP Program within 5 business days of exam for children referred to a Dentist or other Medical Provider. **Do not complete this form if child is in foster care, managed care plan or private insurance**. For children in foster care: Complete *HCPCFC Medical (Specialty)/Dental Contact Form* for all visits. **For any questions call 530-225-5122**

PATIENT INFORMATION:

Patient Name (Last) (First) (Initial)	**Preferred Language**	**Date of Service** (MM/DD/YY)

Birthdate (MM/DD/YY)	**Age**	**Sex**	**Gender**	**County of Residence**	**Telephone #** (Home or Cell) ( )	**Alternate Phone #** (Work or Other) ( )

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

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

Patient Eligibility	County Code	Aid Code	Identification Number (CIN)

A. Medical Assessment and Referral Section

☐ **No Medical Problems Suspected** ☐ **Blood Lead** **Significant Medical History or Special Conditions:** ☐ No ☐ Yes, Specify: _____

CHDP ASSESSMENT	**Problem Suspected**	**Referred To & Phone Number** *Or* ☐ **Return Visit Scheduled**
☐ **Physical Exam**		
☐ **Nutrition**	**Problem Suspected**	**Referred To & Phone Number** *Or* ☐ **Return Visit Scheduled**
☐ **Developmental**	**Problem Suspected**	**Referred To & Phone Number** *Or* ☐ **Return Visit Scheduled**
☐ **Vision**	**Problem Suspected**	**Referred To & Phone Number** *Or* ☐ **Return Visit Scheduled**
☐ **Hearing**		

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,** applied ☐ **No,** teeth have not erupted ☐ **Ordered FV**, date to be applied: _____
☐ **No,** other reason : _____

☐ **Dental home referral** **Referred To & Phone Number**: _____

C. Additional Comments

D. Referring Provider Information

Service Location: (Office Name, Address, Telephone Number)

Rendering Provider Name: (Print Name)

Rendering Provider Signature: **Date:**

Shasta County Health and Human Services
Public Health Branch
Child Health & Disability Prevention Program

Mailing Address:
2650 Breslauer Way
Redding, CA 96001-4246

Telephone: 530-225-5122 | Toll Free:1-800-300-5122
Fax: 530-225-5017

Care Coordination/Follow-up Form: Completion Instructions

Submit a copy of the form, an EHR patient summary, or an equivalent via fax or mail to the Local CHDP program for a child with Fee-for-Service Medi-Cal or temporary Gateway Coverage if the child has been referred to another provider for the following:

- Medical diagnosis
- Medical treatment
- Dental home
- Dental treatment or
- Scheduled for a return visit

Give a copy of the form or a printout of your EHR patient summary or an equivalent to the responsible parent/guardian indicated on the form.

Explanation of Form Items:

Patient Name. Self-explanatory.

Preferred Language. Self-explanatory.

Date of Service. Enter the date the CHDP service was rendered.

Birthdate. Self-explanatory.

Age. Enter the patient's age with one of the following indicators: "y" for years, "m" for months, "w" for weeks, or "d" for days.

Sex. Enter "F" if the patient is female. Enter "M" if the patient is male.

Gender. Enter the gender the patient identifies with. If information is not available, leave blank.

Patient's County of Residence. Enter the name of the county where patient lives.

Telephone #. Enter home or cellular telephone number, with area code of the responsible person.

Alternate Phone #. Enter work or other telephone number, with area code of the responsible person.

Responsible Person. Enter name of responsible person if the patient is younger than 18 years of age and is not an emancipated minor. Enter the address of where the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY CODE: Enter patient's two-digit County Code.
- AID CODE. Enter patient's two-digit aid code.
- IDENTIFICATION NUMBER. Enter patient's identification number from the Benefits Identification Card (BIC) or Gateway response.

Ethnic Code. Enter the appropriate ethnic code.

A. Medical Assessment and Referral Section:

No Medical Problems Suspected. Enter check mark (✓) if no problem found during CHDP assessment - proceed to Dental Assessment section B

Blood Lead Level. Enter check mark (✓) if referred for Blood Lead test .

Significant Medical History or Special Conditions. Enter significant medical history or medical conditions per history.

CHDP Assessment. Enter check mark (✓) if assessment completed.

Problem Suspected. Enter the diagnosis/problem found during CHDP assessment.

Referred To & Phone Number. Enter name and telephone number of provider or agency patient was referred to.

Return Visit Scheduled. Enter check mark (✓) if a return visit to your office is scheduled related to the diagnosis/problem found.

B. Dental Assessment and Referral Section

Dental Classes. Enter a check mark (✓) for the dental class that pertains to the dental assessment findings.

Fluoride Varnish Applied:

Yes, applied. Enter a check mark (✓) if the patient had fluoride varnish applied during visit.
No, teeth have not erupted. Enter a check mark (✓) if fluoride varnish was not applied due to teeth have not erupted.
Ordered FV, date to be applied. Enter a check mark (✓) if fluoride varnish was ordered and patient is scheduled to return for fluoride varnish application.
No, other reason. Enter a check mark (✓) if appropriate and state reason for not applying fluoride varnish.

Dental Home Referral. Enter a check mark (✓) on the *Dental home referral* box when dental referral is made.

Referred To & Phone Number. Enter name and number of dental provider patient was referred to or the patient's regular dental provider.

**Note: A referral for a routine dental visit needs to be made if the patient has no dental problems (Class I) and is 1 year of age or older.*

C. Additional Comments Section.

Comments. Enter remarks that clarify the results of the health assessment or any communication to aid in care coordination to the local CHDP program.

D. Referring Provider Information

Service Location. Self-explanatory. A provider stamp is acceptable.