ADDITIONAL VISIT (AV) FORM

HIGH RISK INFANT FOLLOW-UP

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

**Required Field*

*** DATE OF ADDITIONAL VISIT:** ☐☐-☐☐-☐☐☐☐ (MM-DD-YYYY)

*** This visit was conducted:** ☐ In-person ☐ Telehealth (audio + video observation) ☐ Phone Only

* REASON FOR ADDITIONAL VISIT *(Required Field)*

☐ Social Risk
☐ Concern With Neuro/Developmental Course
☐ Case Management
☐
Other:_____

* DISPOSITION *(Required Field)*

☐ Scheduled To Return
☐ Will Be Followed by Another CCS HRIF Clinic (1)

DISCHARGED:

☐ Graduated
☐ Closed Out of Program
☐ Family Moving Out of State/Country
☐ Family Withdrew Prior To Completion
☐ Will be Followed Elsewhere
☐ Completed HRIF Core Visits, Referred For Additional Resources

AUTISM SPECTRUM SCREEN (Optional)

Does the Child have a Diagnosis of Autism Spectrum Disorder? ☐ **No** ☐ **Yes**

Was an Autism Spectrum Screen Performed During this Visit? ☐ **No** ☐ **Yes** *(complete below)*

Screening Tool Used:	☐ M-CHAT-RF ☐ CSBS-DP ☐ Other/Not Listed	***Screening Results:***	☐ Pass ☐ Did Not Pass	***M-CHAT-RF Risk Level:***	☐ Low Risk ☐ Medium Risk ☐ High Risk

Was the Child Referred for Further Autism Spectrum Assessment? ☐ **No** ☐ **Yes**

Was an ASD diagnosis made at this visit (i.e. concurrent DBP evaluation)? ☐ **No** ☐ **Yes** *(complete below)*

How was the diagnosis made: ☐ Autism Diagnostic Observation Schedule (ADOS) ☐ Other Diagnostic Tools ☐ Other Clinical Evaluation

HOSPITAL/CENTER INFORMATION (Optional)

Hospital Specific Medical I.D. # ☐☐☐☐☐☐☐☐☐☐

Infant's First Name:

Infant's Last Name:

Infant's AKA-1 Last Name:

Infant's AKA-2 Last Name:

Primary Caregiver's First Name:

Primary Caregiver's Last Name:

Street Address:

City: **State:** CA **Zip Code:** ☐☐☐☐☐

Home Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

Alternate Street Address:

Alternate City: **State:** CA **Zip Code:** ☐☐☐☐☐

Alternate Phone Number: (☐☐☐) ☐☐☐-☐☐☐☐

(1) Learn How To Transfer a Record to Another CCS HRIF Clinic.