ADDITIONAL VISIT (AV) FORM

HIGH RISK INFANT FOLLOW-UP

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

CEREBRAL PALSY (CP) - (Optional)

Was Early Detection of High-Risk Cerebral Palsy Made at this Visit? *(Complete if the Child is < 18 Months Adjusted Age)*

☐ **No** (skip to **Developmental Assessment**)

☐ **Yes**

Select the Assessment Used to Arrive at Early Detection of High-Risk Cerebral Palsy: (check all that apply)

☐ Alberta Infant Motor Scale (AIMS)
☐ Developmental Assessment of Young Children (DAYC)
☐ General Movement Assessment (GMA)
☐ Hammersmith Infant Neurological Exam (HINE)
☐ Motor Assessment of Infants (MAI)
☐ Magnetic Resonance Imaging (MRI)
☐ Neurological exam with GMFCS assessment
☐ Neuro Sensory Motor Developmental Assessment (NSMDA)
☐ Test of Infant Motor Performance (TIMP)
☐ Other: _____

Does the Child Have Cerebral Palsy? *(Complete if the Child is ≥ 18 Months Adjusted Age)*

☐ **No** (skip to **Developmental Assessment**)

☐ **Yes**

☐ **Suspect**

Gross Motor Function Classification System (GMFCS) Adjusted Age: (check only one)

Child 18 - 24 months of age adjusted for prematurity		*Child ≥ 24 - 36 months of age adjusted for prematurity*	
☐ Level I	☐ Level IV	☐ Level I	☐ Level IV
☐ Level II	☐ Level V	☐ Level II	☐ Level V
☐ Level III	☐ Unable to Determine	☐ Level III	☐ Unable to Determine

☐ **Unable to Determine**

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

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