

REFERRAL/REGISTRATION (RR) FORM



*Required Field

HRIF I.D. #

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/Country: CA Zip Code:

Home Phone Number: () -

Alternate Street Address:

City: State/Country: CA Zip Code:

Alternate Phone Number: () -

PROGRAM REGISTRATION INFORMATION

CCS #

Infant **NOT** CPQCC NICU Eligible

*NICU Reference ID - (NICU HCAI ID (formerly OSHPD) - NICU Record ID)

*Date of Birth: (MM-DD-YYYY)

*Birth Hospital:

*Birth Weight: Grams *Gestational Age: Weeks Days (0-6)

*Singleton/Multiple: Singleton Multiple: (ex: 2A)

*Infant's Sex: Male Undetermined Female Unknown *Infant's Ethnicity: Hispanic /Latino Non-Hispanic Unknown

*Infant's Race

check only *ONE*

Single:

Multiracial:

Unknown:

- Black or African American
- Asian
- Native Hawaiian or Other Pacific Islander
- American (North, South or Central) Indian or Alaskan Native
- White
- Other
- Unknown

*Hospital Discharging to Home:

Referring CCS NICU:

*Date of Discharge to Home: (MM-DD-YYYY) Infant Still in Hospital

REFERRAL/REGISTRATION (RR) FORM



***Required Field**

HRIF I.D. #

PROGRAM REGISTRATION INFORMATION - continue

<p>*Birth Mother's Date of Birth</p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM-DD-YYYY) <input type="checkbox"/> Unknown </p>	<p>*Birth Mother's Ethnicity</p> <p> <input type="checkbox"/> Hispanic /Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown </p>
--	---

<p>*Birth Mother's Race</p> <p> <input type="checkbox"/> Single: <input type="checkbox"/> Multiracial: <input type="checkbox"/> Unknown: </p>	<p>check only <u>ONE</u></p> <p> <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American (North, South or Central) Indian or Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown </p>
---	--

***Insurance** (Check all that apply)

<input type="checkbox"/> CCS	<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> Commercial PPO	<input type="checkbox"/> Medi-Cal
<input type="checkbox"/> Point of Service/EPO	<input type="checkbox"/> No Insurance/Self Pay	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown

Primary Caregiver

<input type="checkbox"/> Mother	<input type="checkbox"/> Other Relatives/Not Parents	<input type="checkbox"/> Foster Family/CPS	<input type="checkbox"/> Other
<input type="checkbox"/> Father	<input type="checkbox"/> Non-Relative	<input type="checkbox"/> Pediatric Subacute Facility	<input type="checkbox"/> Unknown
<input type="checkbox"/> Both Parents	<input type="checkbox"/> Foster/Adoptive Family		

Zip Code of Pediatric Subacute Facility, if Checked:

Zip Code of Primary Caregiver Residence:

Education of Primary Caregiver	<input type="checkbox"/> <9 th Grade <input type="checkbox"/> Some College <input type="checkbox"/> Other	<input type="checkbox"/> Some High School <input type="checkbox"/> College Degree <input type="checkbox"/> Unknown	<input type="checkbox"/> High School Degree/GED <input type="checkbox"/> Graduate School or Degree <input type="checkbox"/> Declined
---------------------------------------	--	--	--

Caregiver Employment	<input type="checkbox"/> Full-Time <input type="checkbox"/> Multiple Jobs <input type="checkbox"/> Unknown	<input type="checkbox"/> Part-Time <input type="checkbox"/> Work From Home <input type="checkbox"/> Declined	<input type="checkbox"/> Temporary <input type="checkbox"/> Not Currently Employed
-----------------------------	--	--	---

*Primary Language Spoken at Home (Check only <u>ONE</u>)	<input type="checkbox"/> English <input type="checkbox"/> Armenian <input type="checkbox"/> Hindi <input type="checkbox"/> Korean <input type="checkbox"/> Mon-Khmer/Cambodian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese	<input type="checkbox"/> Spanish <input type="checkbox"/> Cantonese <input type="checkbox"/> Hmong/Miao <input type="checkbox"/> Mandarin <input type="checkbox"/> Punjabi <input type="checkbox"/> Tagalog <input type="checkbox"/> Other: _____	<input type="checkbox"/> Arabic <input type="checkbox"/> Farsi/Persian <input type="checkbox"/> Japanese <input type="checkbox"/> Mixteco <input type="checkbox"/> Russian <input type="checkbox"/> Thai
---	---	---	---

Secondary Language Spoken at Home (Optional – Check only <u>ONE</u>)	<input type="checkbox"/> N/A <input type="checkbox"/> Arabic <input type="checkbox"/> Farsi/Persian <input type="checkbox"/> Japanese <input type="checkbox"/> Mixteco <input type="checkbox"/> Russian <input type="checkbox"/> Thai	<input type="checkbox"/> English <input type="checkbox"/> Armenian <input type="checkbox"/> Hindi <input type="checkbox"/> Korean <input type="checkbox"/> Mon-Khmer/Cambodian <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese	<input type="checkbox"/> Spanish <input type="checkbox"/> Cantonese <input type="checkbox"/> Hmong/Miao <input type="checkbox"/> Mandarin <input type="checkbox"/> Punjabi <input type="checkbox"/> Tagalog <input type="checkbox"/> Other: _____
---	---	---	---

*MEDICAL ELIGIBILITY PROFILE (Check all that apply)

***Required Section**

<input type="checkbox"/> Birth Weight ≤ 1500 Grams	<input type="checkbox"/> Seizure Activity / Anti-Seizure Meds	<input type="checkbox"/> INO > 4 Hours / Meds for PPHN
<input type="checkbox"/> Gestational age at Birth < 32 Weeks	<input type="checkbox"/> Oxygen > 28 Days and CLD	<input type="checkbox"/> ECMO
<input type="checkbox"/> Persistent Apnea	<input type="checkbox"/> Neonatal Encephalopathy	

CHD Requiring Surgery / Intervention Was the Norwood or a single ventricle palliation procedure performed? No Yes

CCS Cardiac Center: _____

<p>Persistently Unstable Infant:</p> <p> <input type="checkbox"/> Hypoxia <input type="checkbox"/> Acidemia <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypotension Requiring Pressors </p> <p>Intracranial Pathology with Potential for Adverse Neurologic Outcome:</p> <p> <input type="checkbox"/> Intracranial Hemorrhage <input type="checkbox"/> PVL <input type="checkbox"/> Cerebral Thrombosis <input type="checkbox"/> Cerebral Infarction <input type="checkbox"/> Developmental CNS Abnormality <input type="checkbox"/> Other </p>	<p>Cardiorespiratory Depression:</p> <p> <input type="checkbox"/> Apgar Score ≤ 3 at 5 Minutes <input type="checkbox"/> Apgar Score < 5 at 10 Minutes <input type="checkbox"/> pH < 7.0 on an Umbilical Blood Sample <input type="checkbox"/> pH < 7.0 on Blood Gas at < 1 Hour of Age </p> <p>Other Problems that Could Result in Neurologic Abnormality:</p> <p> <input type="checkbox"/> CNS Infection <input type="checkbox"/> Documented Sepsis <input type="checkbox"/> Bilirubin <input type="checkbox"/> Cardiovascular Instability <input type="checkbox"/> HIE <input type="checkbox"/> Other </p>
--	--