STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

*Required Field

***Date of Visit:** ☐☐-☐☐-☐☐☐☐ (MM-DD-YYYY)

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

VISIT ASSESSMENT

***Core Visit** (1) ☐ #1 (4-8 months) ☐ #2 (12-16 months) ☐ #3 (18-36 months)

Zip Code of Primary Caregiver: ☐☐☐☐☐

Chronological Age: ☐☐ Months ☐☐ Days **Adjusted Age:** ☐☐ Months ☐☐ Days

Interpreter Used

☐ **No**

☐ **Yes:**

☐ Spanish	☐ Arabic	☐ Armenian
☐ Cantonese	☐ Farsi/Persian	☐ Hindi
☐ Hmong/Miao	☐ Japanese	☐ Korean
☐ Mandarin	☐ Mixteco	☐ Mon-Khmer/Cambodian
☐ Punjabi	☐ Russian	☐ Sign Language
☐ Tagalog	☐ Thai	☐ Vietnamese
☐ Other:_____		

Insurance (Check all that apply)

☐ CCS	☐ Commercial HMO	☐ Commercial PPO	☐ Medi-Cal
☐ Point of Service/EPO	☐ No Insurance/Self Pay	☐ Other	☐ Unknown

PATIENT ASSESSMENT

Weight	Length	Head Circumference
☐☐.☐☐ (kg) or ☐☐ (lbs) ☐☐ (oz)	☐☐☐.☐ (cm) or ☐☐.☐☐ (in)	☐☐☐.☐ (cm) or ☐☐.☐☐ (in)
Reason NOT Collected: ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other	**Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other	**Reason NOT Collected:** ☐ Not Routinely Done ☐ Unable to Obtain ☐ Other

GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk?

☐ Exclusively ☐ Some ☐ None

Living Arrangement of the Child

☐ Both Parents	☐ One Parent	☐ One Parent/Other Relatives
☐ Other Relatives/Not Parents	☐ Non Relative	☐ Foster/Adoptive Family
☐ Foster Family/CPS	☐ Pediatric Subacute Facility	☐ Other
☐ Unknown		

Education of Primary Caregiver

☐ <9th Grade	☐ Some High School	☐ High School Degree/GED
☐ Some College	☐ College Degree	☐ Graduate School or Degree
☐ Other	☐ Unknown	☐ Declined

Caregiver Employment

☐ Full-Time	☐ Part-Time	☐ Temporary
☐ Multiple Jobs	☐ Work From Home	☐ Not Currently Employed
☐ Unknown	☐ Declined	

Routine Child Care

☐ **None** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply:

☐ Child Care Outside of Home	☐ Home Babysitter/Nanny	☐ Not Used Routinely
☐ Specialized Medical Setting	☐ Other	

Caregiver Concerns of the Child

☐ **None** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply:

☐ Behavioral	☐ Calming/Crying	☐ Feeding & Growth
☐ Frequent Illness	☐ Gastrointestinal/Stooling/Spitting-up	☐ Hearing
☐ Medications	☐ Motor Skills, Movement	☐ Pain
☐ Sensory Processing	☐ Speech & Language	☐ Stress
☐ Sleeping/Napping	☐ Vision	☐ Other

(1) Core Visits: The HRIF Clinic has three core visits that take place during the following recommended time periods: **Visit #1** (4-8 months), **Visit #2** (12-16 months) and **Visit #3** (18-36 months). **NOTE:** Core Visit #1 is the initial first visit to the HRIF Clinic, even if the patient is older than 8 months corrected age.

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

INTERVAL MEDICAL ASSESSMENT

Does the Child have a Primary Care Provider?	☐ **No**	☐ **Yes**	☐ **Unknown**
Does the Primary Care Provider Act as the Child's Medical Home?	☐ **No**	☐ **Yes**	☐ **Unknown**

Hospitalizations Since Last Visit

☐ **No** ☐ **Yes:** ☐☐ Number of Hospitalizations ☐ **Unknown**

If Yes, Check all that apply

Hospitalization Reasons	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Gastrointestinal Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meningitis Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nutrition/Inadequate Growth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Tract Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Rehospitalization(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having Surgeries During Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Surgeries Since Last Visit

☐ **No** ☐ **Yes:** ☐☐ Number of Surgeries ☐ **Unknown**

If Yes, Check all that apply

☐ Cardiac Surgery
☐ Inguinal Hernia Repair
☐ Tracheostomy
☐ Other Gastrointestinal Surgical Procedures
☐ Other Surgical Procedures
☐ Circumcision
☐ Retinopathy of Prematurity
☐ Tympanostomy Tubes
☐ Other Genitourinary Surgical Procedures
☐ Unknown
☐ Gastrostomy Tube Placement
☐ Shunt/Shunt Revision
☐ Other ENT Surgical Procedures
☐ Other Neurosurgical Procedures

Medications Since Last Visit

☐ **No** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply

☐ Actigall
☐ Anti-Seizure Medication
☐ Caffeine
☐ Chest Physiotherapy (inter.)
☐ Inhaled Bronchodilators (inter.)
☐ Levothyroxine
☐ Allergy Medication
☐ Antibiotics/Antifungal
☐ Cardiac Medications
☐ Diuretics
☐ Inhaled Steroids (daily)
☐ Anti-Reflux Medication
☐ Antihypertensive
☐ Chest Physiotherapy (daily)
☐ Inhaled Bronchodilators (daily)
☐ Inhaled Steroids (inter.)
☐ Nutrition Supplements (make selection): ☐ Enteral Nutrition ☐ Dietary Supplements
☐ Oral Steroids
☐ Oxygen (if discontinued also enter chronologic post-natal age: _____ months _____ days)
☐ Viagra (Pulmonary Hypertension)
☐ Unknown
☐ Synagis / Palivizumab or Beyfortus / Nirsevimab
☐ Other

Equipment Since Last Visit

☐ **No** ☐ **Yes** ☐ **Unknown**

If Yes, Check all that apply

☐ Apnea/CR Monitor
☐ Helmet
☐ Oxygen Supplies
☐ Wheelchair
☐ Braces/Castings/Orthotics
☐ Nebulizer
☐ Tracheostomy
☐ Other
☐ Enteral Feeding Equipment
☐ Ostomy Supplies
☐ Ventilator/CPAP/BiPAP
☐ Unknown

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

MEDICAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Medical Services?

☐ **No** (Skip to **Neurosensory Assessment**) ☐ **Yes** (Complete below) ☐ **Unknown** (Skip to **Neurosensory Assessment**)

Allergy / Immunology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Audiology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Cardiology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Craniofacial	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Dermatology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason
Endocrinology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Gastroenterology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Hematology / Oncology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Metabolic / Genetics	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Nephrology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurosurgery	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

MEDICAL SERVICES REVIEW - *continue*

Ophthalmology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Orthopedic	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Otolaryngology (ENT)	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Pulmonology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Surgery	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Urology	☐ **Does Not Need** ☐ **Receiving** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

NEUROSENSORY ASSESSMENT

Vision Assessment History

Does the Child Have History of Retinopathy of Prematurity (ROP)? ☐ No ☐ Yes

Eye Surgery and/or Treatment with Anti-VEGF (i.e., Avastin)? ☐ No ☐ Yes ☐ Scheduled ☐ Unknown

Location of ROP: ☐ Unilateral ☐ Bilateral ☐ Unknown

Does the Child Have Visual Impairment?

☐ **No** (Skip to **Hearing Assessment History**)

☐ **Yes**

A. Impairment Due To: (check all that apply)

☐ No, Type of Impairment at Visit

☐ Strabismus:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Cataract:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Retinoblastoma:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled

☐ Cortical Visual Impairment	☐ Refractive Errors
☐ Nystagmus	☐ ROP
☐ Other	☐ Unknown

B. Location of Impairment: ☐ Unilateral ☐ Bilateral ☐ Unknown

C. Corrective Lens(es) Recommended: ☐ No ☐ Yes ☐ Unknown

D. Corrective Lens(es) Used: ☐ No ☐ Yes ☐ Unknown

E. Is There Functional Vision? ☐ Yes ☐ No *(complete below)*

Location of "Blindness" ☐ Unilateral ☐ Bilateral ☐ Unknown

☐ **Unknown Visual Impairment**

Why is Visual Impairment Unknown?

☐ Exam Results Unknown	☐ No Ophthalmology Exam Performed
☐ Needs Referral for Exam	☐ Referred for Exam, Not Received
☐ Referred, but Service Not Available	☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Insurance/HMO Denied Services	☐ Referred, but Missed Appointment
☐ Referred for Functional Vision Assessment	☐ Functional Vision Assessment in Progress

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

**Required Field*

NEUROSENSORY ASSESSMENT - *continue*

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?

☐ **No** (Skip to **Neurologic Assessment**)

☐ **Yes**

A. Is There Loss in One or Both Ears? ☐ One ☐ Both ☐ Assessment in Progress ☐ Unknown

B. Does the Child Use an Assistive Listening Device (ALD):

☐ No
☐ Yes, ALD Recommended and Received
☐ Yes, ALD Recommended, but Not Received
☐ Unknown

C. Type of ALD(s) Used (check all that apply)

☐ BAHA ☐ Cochlear Implant ☐ FM System
☐ Hearing Aid ☐ Other ☐ Unknown

☐ **Unknown Hearing Loss**

Why is Hearing Loss Unknown?

☐ Exam Results Unknown
☐ Needs Referral for Exam
☐ Referred, but Service Not Available
☐ Referred, but Insurance/HMO Denied Services
☐ No Audiology Exam Performed
☐ Referred for Exam, Not Received
☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Missed Appointment

☐ **Hearing Assessment in Progress** (Skip to **Neurologic Assessment**)

NEUROLOGIC ASSESSMENT

***Was a Neurologic Exam Performed During this Core Visit?**

☐ **Yes** **Date Performed:** ☐☐-☐☐-☐☐☐☐ (MM-DD-YYYY)

☐ **No** **Reason Why Exam NOT Performed:**

☐ Acute Illness
☐ Known SEVERE Developmental Disability
☐ Significant Sensory Impairment/Loss
☐ Behavior Problems
☐ Primary Caregiver Refused
☐ Other Medical Condition
☐ Examiner Not Available
☐ Primary Language
☐ Other

***This Part of the Visit was Done by:** ☐ In-person ☐ Telehealth (audio + video observation) ☐ Phone Only

Summary of Neurologic Assessment

☐ **Normal** (skip to **Developmental Assessment**)

☐ **Abnormal**

☐ **Suspect**

A. Oral Motor Function – Age Appropriate Responses for the Following:

Feeding:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Swallowing:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Management of Secretions:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine

B. Muscle Tone

Neck	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Trunk	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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**Required Field*

NEUROLOGIC ASSESSMENT - *continue*

C. Is There Scissoring of the Legs on Vertical Suspension? ☐ No ☐ Yes

D. Deep Tendon Reflexes:

Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine

E. Are Persistent Primitive Reflexes Present? ☐ No ☐ Yes ☐ Unknown

F. Are Abnormal Involuntary Movements Present? ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Ataxia ☐ Choreoathetoid ☐ Tremors

G. Quality of Movement and Posture: ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Functional Assessment

A. Bimanual Function ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Only Complete if the Child is ≥ 15 Months Adjusted Age

B. Right Pincer Grasp ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

C. Left Pincer Grasp ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

CEREBRAL PALSY (CP)

Was Early Cerebral Palsy Diagnosis Made? *(Complete if the Child is < 18 Months Adjusted Age)*

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

☐ **Yes**

Select the Assessment Used to Arrive at Early Diagnosis of Cerebral Palsy: (check all that apply)

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

DEVELOPMENTAL CORE VISIT ASSESSMENT

***Was a Developmental Assessment Screener or Test Performed During this Core Visit?**

☐ **Yes** **Date Performed:** ☐☐-☐☐-☐☐☐☐ (MM-DD-YYYY)

☐ **No** Reason Why Assessment **NOT** Performed:

- ☐ Acute Illness
- ☐ Known SEVERE Developmental Disability
- ☐ Significant Sensory Impairment/Loss
- ☐ Behavior Problems
- ☐ Primary Caregiver Refused
- ☐ Other Medical Condition
- ☐ Examiner Not Available
- ☐ Primary Language
- ☐ Other

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DEVELOPMENTAL SCREENERS

Ages and Stages Questionnaire 3rd Edition (ASQ-3) - *check appropriate scoring zone*

Communication	☐ On Schedule	☐ Monitor	☐ Below	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ On Schedule	☐ Monitor	☐ Below	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ On Schedule	☐ Monitor	☐ Below	☐ Unable to Assess	☐ Did Not Assess
Problem-Solving	☐ On Schedule	☐ Monitor	☐ Below	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	☐ On Schedule	☐ Monitor	☐ Below	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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DEVELOPMENTAL SCREENERS - *continue*

Bayley Infant Neurodevelopmental Screener (BINS) – *check appropriate range*

Overall Classification:	☐ Low Risk	☐ Medium Risk	☐ High Risk	☐ Unable to Assess

Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - *check appropriate range*

Adaptive Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Communication:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Motor Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain:	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development Screener III (Bayley-III) - *check appropriate range*

Cognitive:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development Screener 4 (Bayley 4) - *check appropriate range*

Cognitive:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Low Risk	☐ Borderline Risk	☐ High Risk	☐ Unable to Assess	☐ Did Not Assess

The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) - *enter score*

Language Auditory (CLAMS)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Adaptive (CAT)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Full Scale Capute	Score: _____	☐ Unable to Assess	☐ Did Not Assess

Warner Initial Developmental Evaluation of Adaptive and Functional Skills (WIDEA-FS) - *enter score*

Self-Care	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Mobility	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social Cognition	Score: _____	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Screener: _____ *– check appropriate range*

Cognitive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development (Bayley-III) "Hardcopy" - *enter score*			
Cognitive Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Bayley Scales of Infant and Toddler Development (Bayley-III) "Computer" - *enter score*			
Receptive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive Composite (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "Hardcopy" - *enter score*			
Cognitive (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Bayley Scales of Infant and Toddler Development 4 (Bayley 4) "Computer" - *enter score*			
Receptive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor (Scaled Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Language (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive (Standard Score)	Score: _____	☐ Unable to Assess	☐ Did Not Assess

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

DEVELOPMENTAL TESTS - *continue*

Battelle Developmental Inventory, 3rd Edition (BDI-3) - *enter score*			
Adaptive Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Revised Gesell and Amatruda Developmental and Neurologic Examination (Gesell) - *enter score*			
Language Development	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Mullen Scales of Early Learning - AGS Edition (Mullen) - *enter score*			
Gross Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Visual Perception	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Early Learning Composite	Score: _____	☐ Unable to Assess	☐ Did Not Assess
The Developmental Assessment of Young Children 2nd Edition (DAYC-2) - *enter score*			
Cognitive	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Physical Development	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Developmental Profile 3 (DP-3) - *enter score*			
Physical	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Developmental Profile 4 (DP-4) - *enter score*			
Physical	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Adaptive Behavior	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Cognitive	Score: _____	☐ Unable to Assess	☐ Did Not Assess
Communication	Score: _____	☐ Unable to Assess	☐ Did Not Assess

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

DEVELOPMENTAL TESTS - *continue*

Other/Not Listed Test:_____ - *check appropriate range*

Cognitive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other:	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

AUTISM SPECTRUM SCREEN (Optional)

Has a Diagnosis of Autism Spectrum Disorder Been Made? ☐ **No** ☐ **Yes** *(Skip to* **Early Start Program)**

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 Infant 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

EARLY START (ES) PROGRAM

Is the Child Currently Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? *(check only one)*

☐ **Yes** ☐ **No, Complete** ☐ **No, Not Required** ☐ **No, Referred at Visit** ☐ **No, Referral Failure**
☐ **No, Pending Services** ☐ **No, Parent Refused** ☐ **No, Determined Ineligible by ES** ☐ **Unknown**

MEDICAL THERAPY PROGRAM (MTP)

Is the Child Currently Receiving Services Through CCS Medical Therapy Program (MTP)? *(check only one)*

☐ **Yes** ☐ **No, Complete** ☐ **No, Not Required** ☐ **No, Referred at Visit** ☐ **No, Referral Failure**
☐ **No, Pending Services** ☐ **No, Parent Refused** ☐ **No, Determined Ineligible by ES** ☐ **Unknown**

SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?

☐ **No** (Skip to **Resources and Social Concerns**) ☐ **Yes** (Complete below) ☐ **Unknown**

Behavior Intervention	☐ **Does Not Need**	**Referred, but Not Receiving** (check reason)	
	☐ **Receiving**	☐ Missed Appointment	☐ Waiting List / Visit Pending
	☐ **Receiving - Increase Frequency**	☐ Re-Referred	☐ Insurance/HMO Denied
	☐ **Complete**	☐ Service Not Available	☐ Service Cancelled
	☐ **Referred at Time of Visit**	☐ Parent Declined/Refused Service	☐ Other/Unknown Reason
	Service Provider:		
	☐ Early Intervention Specialist	☐ Licensed Clinical Social Worker	☐ Psychologist
	☐ Other	☐ Unknown	
Feeding Therapy	☐ **Does Not Need**	**Referred, but Not Receiving** (check reason)	
	☐ **Receiving**	☐ Missed Appointment	☐ Waiting List / Visit Pending
	☐ **Receiving - Increase Frequency**	☐ Re-Referred	☐ Insurance/HMO Denied
	☐ **Complete**	☐ Service Not Available	☐ Service Cancelled
	☐ **Referred at Time of Visit**	☐ Parent Declined/Refused Service	☐ Other/Unknown Reason
	Service Provider:		
	☐ Early Intervention Specialist	☐ Certified Lactation Consultant	☐ Home Health Agency
	☐ Occupational Therapist	☐ Physical Therapist	☐ Public Health Nurse
	☐ Registered Dietitian	☐ Registered Nurse	☐ Speech/Language Pathologist
	☐ Other	☐ Unknown	

STANDARD VISIT (SV) FORM

HIGH RISK INFANT FOLLOW-UP

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

SPECIAL SERVICES REVIEW – *continue*

Infant Development Services

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ Early Intervention Specialist
- ☐ Physical Therapist
- ☐ MSW
- ☐ Unknown
- ☐ Licensed Clinical Social Worker
- ☐ Psychologist
- ☐ Speech/Language Pathologist
- ☐ Occupational Therapist
- ☐ Registered Nurse
- ☐ Other

Hearing Services

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ Audiologist
- ☐ Speech/Language Pathologist
- ☐ Unknown
- ☐ Early Intervention Specialist
- ☐ Teacher of the Deaf
- ☐ ENT
- ☐ Other

Nutritional Therapy

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ Certified Lactation Consultant
- ☐ Registered Dietitian
- ☐ Unknown
- ☐ Public Health Nurse
- ☐ Registered Nurse
- ☐ Physician
- ☐ Other

Occupational Therapy (OT)

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ Occupational Therapist
- ☐ Other
- ☐ Unknown

Physical Therapy (PT)

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ Physical Therapist
- ☐ Other
- ☐ Unknown

Speech / Language Communication

- ☐ **Does Not Need**
- ☐ **Receiving**
- ☐ **Receiving - Increase Frequency**
- ☐ **Complete**
- ☐ **Referred at Time of Visit**

Referred, but Not Receiving (check reason)

- ☐ Missed Appointment
- ☐ Re-Referred
- ☐ Service Not Available
- ☐ Parent Declined/Refused Service
- ☐ Waiting List / Visit Pending
- ☐ Insurance/HMO Denied
- ☐ Service Cancelled
- ☐ Other/Unknown Reason

Service Provider:

- ☐ American Sign Language
- ☐ Speech/Language Pathologist
- ☐ Early Intervention Specialist
- ☐ Other
- ☐ Teacher of the Deaf
- ☐ Unknown

STANDARD VISIT (SV) FORM

HRIF HIGH RISK INFANT FOLLOW-UP

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

SPECIAL SERVICES REVIEW – *continue*

Social Work Intervention	☐ **Does Not Need** ☐ **Receiving** ☐ **Receiving - Increase Frequency** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Clinical Social Worker ☐ Physician ☐ Unknown	☐ Marriage & Family Therapist ☐ MSW	☐ Psychologist ☐ Other
Visiting, Public Health, and /or Home Nursing	☐ **Does Not Need** ☐ **Receiving** ☐ **Receiving - Increase Frequency** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Vocational Nurse ☐ Registered Nurse	☐ Physician ☐ Other	☐ Public Health Nurse ☐ Unknown
Vision Services	☐ **Does Not Need** ☐ **Receiving** ☐ **Receiving - Increase Frequency** ☐ **Complete** ☐ **Referred at Time of Visit**	**Referred, but Not Receiving** (check reason) ☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List / Visit Pending ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Low Vision Specialist (Optometrist) ☐ Orientation & Mobility Specialist ☐ Other	☐ Low Vision Specialist (Ophthalmologist) ☐ Physical Therapist ☐ Unknown	☐ Occupational Therapist ☐ Teacher of the Visually Impaired

SOCIAL CONCERNS AND RESOURCES

Caregiver-Child Disruptions or Concerns *Single parent, divorce, prolonged separation (incarceration, military service) multiple changes in caregivers/daycare, caregiver chronic illness*	☐ No ☐ Already Receiving Services	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Economic/Environmental Concerns/Stressors *Housing insecurity, lack of resources-$$, insurance (or high co-pay), lack of reliable transportation for medical needs*	☐ No ☐ Already Receiving Services	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Community & Relationship Concerns *Emotional support from family/friends, supportive and safe intimate relationship, safe neighborhood, and resources for needs*	☐ No ☐ Already Receiving Services	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Parent-Child Concerns *Feeding & growth, calming, behavior, sleep, other*	☐ No ☐ Already Receiving Services	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Food Insecurity *Lack of resources$$ to purchase food, not enough food to feed the family*	☐ No ☐ Already Receiving Services	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources

CHILD PROTECTIVE SERVICES (CPS)

Is a Child Protective Services Case Currently Opened?

☐ **No** ☐ **Yes** ☐ **Referred at Time of Visit**

STANDARD VISIT (SV) FORM

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

**Required Field*

OTHER MEDICAL CONDITIONS

Has the Child's Immunization Schedule Ever Been Delayed? ☐ **No** ☐ **Yes** ☐ **Unknown**

Were there Additional Medical Conditions Identified that may Impact the Child's Outcome? ☐ **No** ☐ **Yes** (complete below)
(check all categories that apply and provide a description of the diagnosis)

- ☐ **Cardiovascular and Circulatory:**
- ☐ **Endocrine and Metabolic:**
- ☐ **Eye, Ear, Nose:**
- ☐ **Gastrointestinal and Hepatobiliary:**
- ☐ **Genetic:**
- ☐ **Hematologic, Immunologic, or Oncologic/Neoplasm:**
- ☐ **Infectious Diseases:**
- ☐ **Injuries, Accident, Poisoning:**
- ☐ **Renal and Genitourinary Tract:**
- ☐ **Respiratory System:**
- ☐ **Nervous System:**
- ☐ **Other:**

*DISPOSITION *(Required Field)*

- ☐ Scheduled to Return
- ☐ Completed HRIF Core Visits, Scheduled to Return
- ☐ Will be Followed by Another CCS HRIF Clinic (1)

DISCHARGED:

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

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