

ADDITIONAL VISIT (AV) FORM

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 (I)

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

- ☐ Level I ☐ Level IV
☐ Level II ☐ Level V
☐ Level III ☐ Unable to Determine

Child ≥ 24 - 36 months of age adjusted for prematurity

- ☐ Level I ☐ Level IV
☐ Level II ☐ Level V
☐ 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:	<input type="checkbox"/> M-CHAT-RF <input type="checkbox"/> CSBS-DP <input type="checkbox"/> Other/Not Listed	Screening Results:	<input type="checkbox"/> Pass <input type="checkbox"/> Did Not Pass	M-CHAT-RF Risk Level:	<input type="checkbox"/> Low Risk <input type="checkbox"/> Medium Risk <input type="checkbox"/> High Risk
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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](#).