Santa Clara County Public Health Department

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

CARE COORDINATION FORM

1993 McKee Rd., Bldg. B, San Jose, CA 95116 | Office: (408) 937-2250

Patient Label [optional]

Patient name, birthdate, age and gender, if available. If patient label is provided, you do not need to re-enter the information on this form.

ELIGIBILITY: For patients ages 0 to 21 actively enrolled in **Fee For Service Medi Cal** or **Gateway Medi Cal**.

DO NOT COMPLETE for patients in foster care: Providers are required to submit a Foster Care Medical/Dental Exam form.

SUBMIT FORM TO: *SCCPHD CHDP within 5 business days of examination*

Mail: 1993 McKee Rd., Bldg. B, San Jose, CA 95116 | Secure Fax: (408) 937 2252 | Email: CHDP@phd.sccgov.org

A. Patient Information

Today's Date: *Month/Day/Year*	Date of Service: *Month/Day/Year*	Health Coverage: ☐ Medi-Cal FFS ☐ Gateway			
If no coverage, referred to:		Date of Birth: *Month/Day/Year*		Age:	Sex: ☐ M ☐ F
Patient: *Last name*	*First name*	*Middle name*		Language:	Is patient homeless: ☐ Y ☐ N
County of Residence: Santa Clara		Telephone # (home or cell):		Alternative # (work or other):	
Responsible Person: *First name, Last name*		Address: *Street, Apt/Space#*		*City*	*Zip*
Patient Eligibility:	County: 43	Aid:	Medi-Cal Identification # (BIC):	Next CHDP Exam date: *Month/Day/Year*	Pt Ethnic Code: 1. ☐ American Indian 2. ☐ Asian 3. ☐ Black 4. ☐ Filipino 5. ☐ MexAmer/Hispanic 6. ☐ White 7. ☐ Pacific Islander 8. ☐ Other 9. ☐ Declined

B. Medical Assessment and Referral

Medical History & Physical Exam	Problem suspected:		Referred to: *Name of clinic & provider*	Telephone #:	Return visit date: *Month/Day/Year*
Dental Assessment	Had dental visit in the last 6 months: ☐ Y ☐ N				
	Has a dental home: ☐ Y ☐ N	If Yes, where: *Name of clinic* *Telephone #*	If No, referred to: *Name of clinic* *Telephone #*		
	Fluoride varnish applied: ☐ Y ☐ N	If No, why: ☐ Parent refused ☐ Teeth have not erupted ☐ Other reason:			
	☐ **Class I**: **No visible problems.** *Mandated annual routine dental referral beginning no later than age 1 and recommended every 6 months.* **Routine Dental Referral.**	☐ **Class II**: **Visible problem.** *Visible decay, small carious lesion, or gingivitis.* **Needs non-urgent dental care.**	☐ **Class III:** **Urgent problem.** *Pain, abscess, large carious lesions, or extensive gingivitis.* **Needs immediate treatment** *for urgent dental condition, which can progress rapidly.*	☐ **Class IV:** **Emergent problem.** *Acute injury, oral infection, or other pain.* **Needs immediate treatment within 24 hours.** Please call 408-808-6102.	
Nutrition Assessment	Problem suspected:		Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Obesity	☐ Y ☐ N	Height: Weight: Head Circumference: BMI Percentile: BMI Index:	Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Developmental Assessment *Tool used*	☐ Y ☐ N	☐ Cognitive Delay ☐ Fine Motor Delay ☐ Gross Motor Delay ☐ Speech Delay ☐ Social Emotional	Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Vision Screening *Tool used*	☐ Y ☐ N	If yes, problem suspected:	Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Hearing Screening *Tool used*	☐ Y ☐ N	If yes, problem suspected:	Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Lead Screening	☐ Y ☐ N	Lead: Hgb/HCT:	**Immunization record current:** ☐ Y ☐ N		
Behavioral Health Assessment	Diagnosis:		Referred to: *Name of clinic & provider or CBO*	Telephone #:	Return visit date: *Month/Day/Year*
Tuberculosis	Risk assessment: ☐ Y ☐ N	TST Place: ☐ Y ☐ N QFT-G: ☐ Y ☐ N	mm: Result: ☐ Positive ☐ Negative	Date read:	
Comments					

C. Referring Provider Information

Facility name:	Address: *Street, Apt/Space#* *City* *Zip*	
Provider name: *First, Last, Title*	Provider NPI #:	Telephone # (office):
Provider signature:		Date: