California Children's Services (CCS)
High Risk Infant Follow-Up Program
HEALTH and DEVELOPMENTAL STATUS REPORT

Instructions: This information must be collected at the initial assessment, routine follow-up visits, and at the final assessment. ***Fax the completed form to the toll free number (866) 418-2933. If you have any questions, call Kimie Kagawa, M.D. at (916) 327-2665 or Rachel Luxemberg, M.A. at (916) 327-1443.***

SECTION A: CLIENT TRACKING INFORMATION

1. CCS Number: ☐☐☐☐☐☐☐☐ ***or*** **HRIF Identification Number:** ☐☐☐☐☐☐☐☐

2. Date of Assessment (MM/DD/YYYY): ☐☐/☐☐/☐☐☐☐ **3. Zip Code of Residency:** ☐☐☐☐☐

4. Enter Your NICU's CPQCC Center Number: ☐☐☐☐

5. Assessment Visit:
Check all that are applicable

(√)	Option	(√)	Option
☐	Client Seen	☐	Client Not Seen

(√)	Option
☐	Completed Assessment
☐	Incomplete or Partial Assessment Performed
☐	No Follow-Up Required Per HRIF Program

(√)	Option
☐	Failed Appointment
☐	Too Sick to be Evaluated
☐	Other

If client failed to show up, check all that are applicable

(√)	Option	(√)	Option	(√)	Option
☐	Left Geographic Area	☐	Expired	☐	Rescheduled
☐	Lost to follow-up	☐	Authorization Pending	☐	Not Authorized
☐	Other/Unknown				

6. Insurance Status: *Check (√) all that apply at time of each visit*

☐ a. Medi-Cal ☐ b. Healthy Families ☐ c. CCS-Only ☐ d. Commercial PPO ☐ e. Commercial HMO

SECTION B: GROWTH PARAMETERS AT TIME OF VISIT

7. Weight: ☐☐☐☐☐gm **8. Length:** ☐☐☐.☐cm **9. Head Circumference:** ☐☐.☐☐cm

SECTION C: MEDICAL REHOSPITALIZATION

10. If the child was rehospitalized, check *(√)* the category for rehospitalization.

☐ a. Pulmonary ☐ b. GI ☐ c. Cardiac ☐ d. Neurological ☐ e. Other

SECTION D: VISION IMPAIRMENT

11. Visual Impairment:
Check (√) only one ☐ Unilateral ☐ Bilateral ☐ Unsure ☐ No Visual Impairment

12. Blindness Present:
Check (√) only one ☐ Unilateral ☐ Bilateral ☐ Unsure ☐ Not blind

SECTION E: HEARING IMPAIRMENT

13. Hearing Impairment:
Check (√) only one ☐ Unilateral ☐ Bilateral ☐ Unsure ☐ No Hearing Impairment

14. Deafness Present:
Check (√) only one ☐ Unilateral ☐ Bilateral ☐ Unsure ☐ No Deafness Present

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SECTION F: CEREBRAL PALSY

Check (√) all that apply

15. Cerebral Palsy: ☐ Yes ☐ No

a. If Yes, Impairment: ☐ Diplegia ☐ Hemiplegia ☐ Quadriplegia ☐ Monoplegia ☐ Other

b. If No, Muscle Tone: ☐ Normal ☐ Abnormal

c. If Muscle tone is abnormal: ☐ Hypotonia ☐ Hypertonia ☐ Both (hypotonia & hypertonia)

SECTION G: DEVELOPMENTAL TESTING

16. Please place a check (√) by each test used.

Test	(√)	Test	(√)	Test	(√)	Test	(√)
BSID-II (2nd Edition)		Bayley Screener		Gesell Developmental Schedule		Other _____	
BSID-III (3rd Edition)		CAT/CLAMS		Mullen Scale		Other _____	
BINS		Denver II		WPPSI		Other _____	

Use of a norm-referenced assessment test is highly recommended. For norm referenced tests, classify infants in the following way:
***Normal Development** – Obtained score is within one standard deviation or above (>85, if mean is 100 and standard deviation (SD) is 15).*
***Borderline Development** – Obtained score is between 1 and 2 SD below the mean (70 – 84 if the mean is 100 and SD is 15).*
***Deficient Development** – Obtained score is greater than 2 SD below the mean (<70 if mean is 100 and SD is 15).*

Based on the standardized range please check (√) the category that best describes the child's developmental status.

	Developmental Status	Normal	Borderline	Deficient	Unable to Assess
17.	**Cognitive Function**				
18.	**Motor Development**				
	a. Fine Motor				
	b. Gross Motor				
19.	**Language Development**				

If your instrument has a global or composite score, report this score in Item 20 (Overall Clinical Appraisal of cognitive functioning).

20. Overall Clinical Appraisal of child's cognitive functioning:

Check (√) only one

☐ Normal ☐ Suspect ☐ Impaired ☐ Unable to assess

SECTION H: CURRENT INTERVENTION

20. If the child is receiving current interventions, please check (√) all responses that apply.

(√)	Intervention	(√)	Intervention	(√)	Intervention
	Early Start		Speech Therapy		No Intervention
	Occupational Therapy		Medical Therapy Unit		Other: _____
	Physical Therapy		Home Visit Evaluation		

Please provide the following information for the person completing this form.

Name: _____ **Phone:** _____ **Date Completed:** _____