

**California Children’s Services (CCS)
High Risk Infant Follow-Up (HRIF) Program
HRIF Team Visit Report Form**

Instructions: The purpose of this form is to provide key HRIF program visit information required by the CCS Program or Regional Office for ongoing case management purposes. In addition to submitting this form to the CCS Program or Regional Office, a copy of this information is also to be submitted to the child’s pediatric primary care provider or medical home, NICU medical director (if the director is not the HRIF program medical director) and other providers involved in the care of the child*. This form contains elements required by CCS for case management. Please attach copies of the (dictated) history and physical, and other pertinent reports.

Child’s Name: _____	Name of HRIF Program: _____
HRIF Visit Date: ____/____/____	CCS HRIF SCC Directory Number: 7 . ____ . ____
CCS Number: _____	Team Members: <i>Write in team member names on the lines provided.</i>
Birth Date: ____/____/____	(✓) <i>Check members whose findings are attached.</i>
Current Medical Home Provider: <i>Write the medical home provider on the lines provided.</i>	<input type="checkbox"/> _____
_____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> _____
_____	<input type="checkbox"/> _____

Attach the following:

- 1) **Summary of Key Findings and Recommendations (i.e., History and physical exam, motor/neurological, developmental exam and pertinent findings for audiology, ophthalmology, and psychosocial assessments).**
- 2) **A copy of the physician report which addresses the physical exam findings and recommendations for CCS case management.**

*** Check all that received a copy of this report form.**

<u>Copy Required</u>	<u>Interventions / Other Providers</u>
<input type="checkbox"/> CCS / Regional Office	<input type="checkbox"/> Early Start
<input type="checkbox"/> NICU Director (if other than the HRIF Medical Director)	<input type="checkbox"/> Other Providers or Special Care Centers involved (Please list below)
<input type="checkbox"/> Medical Home	<input type="checkbox"/> Medical Therapy Unit _____
	<input type="checkbox"/> Occupational Therapist _____
	<input type="checkbox"/> Physical Therapist _____
	<input type="checkbox"/> Speech Therapist _____