| DO NOT STAPLE<br>N BAR AREA   |   |   | CLAIM C   | CONTROL NUMBER                                  | FOR STATE USE ONLY   | STAPLE<br>HERE   |
|---|---|---|---|---|--|--|
| P PATIENT NAME (LAST)   |   | (FIRST)                                   | Car   | 17.1  | MEDICAL RECORD NO. OO1 Code 94   | 05778291   |
| S BIRTHDATE AGE Day Year RESPONSIBLE PERSON (NAME)  | M   | (STREET)                                  | (11/1/22/1/20=  | CO, CODE TEL                                    | EPHONE NUMBER NEXT CHOP EXAM No. Day Ye  (CITY) (ZIP)  | ar 2. American Indian 2. Asian 3. Black Code 4. Filipino 5. Mex. Amer. Afispanic 6. White 7. Other 8. Pacific Islander |
| CHDP ASSESSMENT Indicate outcome for each screening procedure   | NO PROBLEM SUSPECTED NOT NEEDED VA B                                    | Enter Folk                                | SUSPECTED<br>ow Up Code<br>in<br>the Column<br>KNOWN<br>D | DATE OF SERVICE Mo. Day FEES                    | 1. NO DX/RX INDICATED OR NOW<br>UNDER CARE.<br>2. QUESTIONABLE RESULT, RECHECK<br>SCHEDULED.   | 4. DX PENDING/RETURN VISIT SCHEDULED.  |
| 1 HISTORY and PHYSICAL EXAM   |   |   |   |   | REFERRED TO:   | TELEPHONE NUMBER   |
| 02 DENTAL ASSESSMENT/REFERRAL   |   |   |   | 01  | REFERRED TO:   | TELEPHONE NUMBER   |
| 03 NUTRITIONAL ASSESSMENT 04 ANTICIPATORY GUIDANCE 05 DEVELOPMENTAL ASSESSMENT 05 SNELLEN OR EQUIVALENT 05 AUDIOMETRIC 05 HEMOGLOBIN OR HEMATOCRIT 05 URINE DIPSTICK 05 COMPLETE URINALYSIS 05 TB MANTOUX 06 GTHER TESTS PLEASE RE 05 PLEASE RE 06 PLEASE RE 07 PLEASE RE 07 PLEASE RE 07 PLEASE RE | FER TO THE CHDP  S BODY MASS INDE (BMI) PERCENTILE                      | X BLOOD PRE                               | ESSURE  | 06 07 08 09 10 12 CODE OTHER TESTS              | COMMENTS/P  IF A PROBLEM IS DIAGNOSED THE YOUR DIAGNOSIS IN  | HS VISIT, PLEASE ENTER<br>I THIS AREA  |
|   | GIVEN TODAY   | BIRTH WEX<br>LBS<br>NOT GIV               | OZS<br>EN TODAY   |   | ROUTINE REFERRAL(S) (V) P. BLOOD LEAD DENTAL   | ATIENT IS A FOSTER CHILD (V)   |
| IMMUNIZATIONS   | NOW UP STILL NO TO DATE UP TO   | UP TO                                     | REFUSED<br>OR   |   | DIAGNOSIS (  | CODES 2  |
| PLEASE REFER TO THE CHDP<br>LIST OF IMMUNIZATION CODES  | FOR DATE FOR AGE AGE B  | DATE FOR AGE                              | NOICATED<br>D   |   |  |  |
|   |   |   |   |   | THE QUESTION<br>MUST BE ANS  | S BELOW<br>SWERED  |
|   |   |   |   |   | 1. Patient is Exposed to Passive (   |  |
|   |   | -   |   |   | Hand) Tobacco Smoke.  2. Tobacco Used by Patient   | Yes □ No □   |
|   |   |   |   |   |  | res [  |
| PATIENT VISIT (  New Patient or 2 Acutine Visit   | TVPE  | OF SCREEN (                               | √)<br>Wiodic  | TOTAL FEES                                      | Counseled About/Referred For Tobacco Use Prevention/ Cessation.  | Yes No No  |
| ERVICE LOCATION: Name, Address, relephone Number Please Include Area Code)  this is to certify that the screening informs parent or guardian. I understand that   |   |   |   |   | NOTE: WIC requires Ht., Wt. and  1 PARTIAL SCREEN 2 SCREE  ACCOMPANIES PRIOR PM 160 DATED  PATIENT COUNTY AID IDENTIFICATIO  ELIGIBILITY | NING PROCEDURE RECHECK  N NUMBER  Bed in CHOP Gataway, enter BIC number.   |
| unds, and that any false claims, statemer<br>under applicable Federal or State law. I<br>will be billed to Medi-Cal, the patient, or<br>agnature of PROVIDER.   | nts or documents or c<br>also certify that none<br>other insurance prov | oncealment of<br>of the service<br>iders. | t a material fa<br>as billed on<br>TE                     | act, may be prosecuted<br>this form have been o | STATE OF CALIFORNIA-CHILD HEALTH AND   | DISABILITY PREVENTION PROGRA<br>edi-Cal/CHDP<br>). Box 15300<br>cramento, CA 95851-1300                                |

| D NOT STAPLE<br>BAR AREA   |                                |  |                     | CLAIM C   | ONTROL NUMBER                                    | FOR STATE USE ONLY  | STAPLE<br>HERE   |
|--|--------------------------------|--|---------------------|---|--|---|--|
| PATIENT NAME (LAST)  |                                | -  | FIRST)              | P   | ete  | MEDICAL RECORD NO. Code 94  | 4 05778291   |
| Mg. BIRTHDATE Vear 4 RESPONSIBLE PERSON (NAME)   | SEX M/F P/                     | W. 7. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 1. 10 | TREET)              | ESIDENCE  | 100000000000000000000000000000000000000          | EPHONE NUMBER NEXT CHOP EXA Day (CITY) (ZIP)  |  |
| HDP ASSESSMENT Indicate outcome for each screening procedure   | NO<br>PROBLEM<br>SUSPECTED     | REFUSED,<br>CONTRA-<br>MOICATED,<br>NOT<br>NEEDED<br>J B   | Enter Folio         | SUSPECTED<br>w Up Code<br>n<br>de Column<br>KNOWN | DATE OF SERVIC                                   | 1. NO DX/RX INDICATED OR NOW UNDER CARE.  | UP CODES  4. DX PENDING/RETURN VISIT SCHEDULED.  K 5. REFERRED TO ANOTHER EXAMINI FOR DX/RX. 6. REFERRAL REFUSED   |
| HISTORY and PHYSICAL EXAM  |                                |  |                     |   | 01   | REFERRED TO:  | TELEPHONE NUMBER   |
| 2 DENTAL ASSESSMENT/REFERRAL   |                                |  |                     |   | 01   | REFERRED TO:  | TELEPHONE NUMBER   |
| JIGHT IN INCHES WEICHT OZ  |                                | ASS INDEX<br>RCENTILE  | BLOOD PRE           | SSURE   | 06   07   08   09   10   12   CODE   OTHER TESTS | ROUTINE REFERRAL(S) (V)  BLOOD LEAD DENTAL  DIAGNOSE  THE QUESTIC MUST BE AL                                | PATIENT IS A FOSTER CHILD (V S CODES 2   |
|  |                                |  |                     |   |  | Patient is Exposed to Passive Hand) Tobacco Smoke.     Tobacco Used by Patient                              | 12 Table 1 Tab |
| PATIENT VISIT (√)  1 New Patient or Patient of Patient of Visit Routine Visit  |                                | TYPE O   | F SCREEN (          | √)<br>eriodic                                     | TOTAL FEES                                       | 3. Counseled About/Referred For<br>Tobacco Use Prevention/<br>Cessation.                                    | or Yes No  |
| RVICE LOCATION: Name, Address, dephone Number (Please Include Area Code)  is is to certify that the screening infor parent or guardian. I understand that                | mation is true                 | d satisfacti   | on of this ci       | laim may be                                       | from Federal or State                            | ACCOMPANIES PRIOR PM 160 DATED PATIENT COUNTY AID IDENTIFICATE LIGIBILITY  If covered by Medi-Cal, or pre-e | EENING PROCEDURE RECHECK  TOON NUMBER  Involled in CHDP Gateway, enter BIC number.   |
| nds, and that any false claims, statement<br>der applicable Federal or State law. I<br>Il be billed to Medi-Cal, the patient, or<br>NATURE OF PROVEER  ONFIDENTIAL SCREE | also certify t<br>other insura | hat none of<br>nce provide   | the service<br>ers. | s billed on                                       | this form have been o                            | STATE OF CALIFORNIA-CHILD HEALTH A  | ND DISABILITY PREVENTION PROGR<br>Medi-Cal/CHDP<br>P.O. Box 15300<br>Sacramento, CA 95851-1300   |

| DO NOT STAPLE<br>N BAR AREA  |  |  | CLAIM C  | ONTROL NUMBER   | FOR STATE USE ONLY  | STAPLE<br>HERE   |
|--|--|--|--|---|---|--|
| P PATIENT NAME (LAST)  BIRTHDATE AGE  Mu. Day Vear   | The second secon | (FIRST)                                | Y L  | Liz   | MEDICAL RECORD NO.  OO3  EPHONE NUMBER  NEXT CHIDP EXI  Mo.  Day  | Year 2-Asian   |
| RESPONSIBLE PERSON (NAME)  | F  | (STREET)                               |  | (APT/SPACE #)   | (CITY) (ZIP)  | Ethnic 3-Black<br>4-Filipino<br>5-Mex, Amer,/Hispanic<br>6-White<br>7-Other<br>8-Pacific Islander                  |
| CHDP ASSESSMENT Indicate outcome for each screening procedure  | NO COMPROBLEM MICH. SUSPECTED N  | VTRA- Enter Folio                      | SUSPECTED<br>ow Up Code<br>of the Column<br>KNOWN<br>D | DATE OF SERVICE Day FEES                              | 1. NO DX/RX INDICATED OR NOW UNDER CARE.  | / UP CODES 4. DX PENDING/RETURN VISIT SCHEDULED. CX 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED |
| 1 HISTORY and PHYSICAL EXAM  |  |  |  | 01  | REFERRED TO:  | TELEPHONE NUMBER   |
| 02 DENTAL ASSESSMENT/REFERRAL<br>03 NUTRITIONAL ASSESSMENT   |  |  |  |   | REFERRED TO:  | TELEPHONE NUMBER   |
| 04 ANTICIPATORY GUIDANCE 05 DEVELOPMENTAL ASSESSMENT 5 SNELLEN OR EQUIVALENT 7 AUDIOMETRIC 8 HEMOGLOBIN OR HEMATOCRIT 9 URINE DIPSTICK 0 COMPLETE URINALYSIS 2 TB MANTOUX  | FER TO THE CH  | DP LIST OF TES                         | T CODES  | 06   07   08   09   10   12   12   CODE   OTHER TESTS |   | PROBLEMS D THIS VISIT, PLEASE ENTER IS IN THIS AREA  |
| EIGHT IN INCHES WEIGHT OZI   | BODY MASS (BMB) PERCEN   | ITILE<br>BIRTH WEIG<br>LBS             | /  |   | ROUTINE REFERRAL(S) (√)   | PATIENT IS A FOSTER CHILD (V)  |
| IMMUNIZATIONS PLEASE REFER TO THE CHOP LIST OF IMMUNIZATION CODES  | FOR DATE AGE A   | L NOT ALREADY UP TO UP TO DATE FOR AGE | REFUSED<br>OR<br>CONTRA-<br>INDICATED                  |   | DIAGNOSI<br>1   | S CODES  |
| LIST OF IMMONIZATION CODES   | A  | B C:                                   | D  |   | THE QUESTIC MUST BE A   | ONS BELOW  |
| PATIENT VISIT (√)  | T Posses   | TYPE OF SCREEN (-                      | 36   | TOTAL FEES  | Patient is Exposed to Passiv Hand) Tobacco Smoke.     Tobacco Used by Patient     Counseled About/Referred F Tobacco Use Prevention/ Cessation. | e (Second Yes No Yes No Yes No No  |
| Extended Visit  ERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)  This is to certify that the screening informis parent or guardian. I understand that unds, and that any false claims, statement | payment and sa   | d complete, and ti                     | laim may be<br>a material fi                           | from Federal or State                                 | PATIENT COUNTY AID IDENTIFICE   | ATION NUMBER  arrolled in CHDP Gateway, enter BIC number.  |
| under applicable Federal or State law. I will be billed to Medi-Cal, the patient, or<br>EGNATURE OF PROVIDER CONFIDENTIAL SCREE  | other insurance ;  | providers.                             | IE.  |   | STATE OF CALIFORNIA-CHILD HEALTH A  | Medi-Cal/CHDP<br>P.O. Box 15300<br>Sacramento, CA 95851-1300   |

| DO NOT STAPLE<br>IN BAR AREA  |   |   |  | CLAIM C  | ONTROL NUMBE   | R • FOR STATE USE ONLY   | STAPLE<br>HERE  |
|---|---|---|--|--|--|--|---|
| PATIENT NAME (LAST)  BIRTHDATE AGE  MO. Day Year 4  RESPONSIBLE PERSON (NAME)   | SEX M/F   | ATIENT'S CO   |  | bri  | ela  | MEDICAL RECORD NO. O 4 Code 94  LEPHONE NUMBER NEXT CHIDP EXAM No. Day Year  ) (CITY) (ZIP)  | 05778291<br>I-American Indian<br>2-Asian<br>3-Black<br>4-Falpino<br>5-Mex. Amer./Hispanid<br>6-White<br>7-Other |
| CHDP ASSESSMENT Indicate outcome for each screening procedure   | NO<br>PROBLEM<br>SUSPECTED<br>VA                            | PERUSED,<br>CONTRA-<br>MORCATED,<br>NOT<br>NEEDED<br>VB | Enter Folio                                | SUSPECTED<br>ow tip Code<br>in<br>the Golumn<br>KNOWN<br>D | DATE OF SERVI  | 1. NO DX/RX INDICATED OR NOW 4. UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK 5. SCHEDULED.  | DX PENDING/RETURN VISIT SCHEDULED.  |
| 1 HISTORY and PHYSICAL EXAM<br>02 DENTAL ASSESSMENT/REFERRAL  |   |   |  |  | 01   | REFERRED TO:   | TELEPHONE NUMBER TELEPHONE NUMBER   |
| O3 NUTRITIONAL ASSESSMENT O4 MATICIPATORY GUIDANCE O5 DEVELOPMENTAL ASSESSMENT O5 DEVELOPMENTAL ASSESSMENT OF SNELLEN OR EQUIVALENT OF AUDIOMETRIC OF HEMOGLOBIN OR HEMATOCRIT OF URINE DIPSTICK OCOMPLETE URINALYSIS OF THE MANTOUX OCODE OTHER TESTS PLEASE RE                                      | BODY  | E CHOP LIS  | ST OF TES                                  |  | 06<br>07<br>08<br>09<br>10<br>12<br>CODE OTHER TESTS | COMMENTS / PROBLEM IS DIAGNOSED THIS YOUR DIAGNOSIS IN TO  | VISIT, PLEASE ENTER   |
| EMOGLOBIN HEMATOCRIT  | 0%  | %   | BIRTH WEN                                  | GHT OZS  |  | ROUTINE REFERRAL(S) (V) PAT  | TENT IS A FOSTER CHILD (V)  |
| IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES   | NOW UP<br>TO DATE<br>FOR<br>AGE<br>A                        | STILL NOT<br>UP TO<br>DATE FOR<br>AGE<br>B              | ALREADY<br>UP TO<br>DATE FOR<br>AGE<br>C   | REFUSED<br>OR<br>CONTRA-<br>INDICATED<br>D                 |  | DIAGNOSIS CO   | 2   |
| PATIENT VISIT (V)  Il Alexa Patient or Z Routine Visit  |   | TYPE O  | F SCREEN (                                 | √)<br>Vieriodic  | TOTAL FEES   | 1. Patient is Exposed to Passive (Se Hand) Tobacco Smoke. 2. Tobacco Used by Patient 3. Counseled About/Referred For Tobacco Use Prevention/ Cessation.  | THE STATE OF THE  |
| ERVICE LOCATION: Name, Address, relephone Number (Please Include Area Code)  this is to certify that the screening informs is parent or guardian. I understand that any false claims, statemender applicable Federal or State taw. I till be billed to Medi-Cal, the patient, or GRATURE OF PROVIDER. | mation is tru<br>payment a.<br>nts or docum<br>also certify | nd satisfacti<br>nents or con<br>that none of           | on of this c<br>cealment of<br>the service | laim may be<br>f a material f<br>es billed on              | from Federal or Stat<br>act, may be prosecute        | NOTE: WIC requires Ht., Wt. and I  I PARTIAL SCREEN 2 SCREENI  ACCOMPANIES PRIOR PM 160 DATED  PATIENT COUNTY AID IDENTIFICATION I  ELIGIBILITY  I f covered by Medi-Cal, or pre-enrolled Patient eligible for CHDP benefits only  STATE OF CALIFORNIA-CHILD HEALTH AND DI  Medi | NG PROCEDURE RECHECK NUMBER  I in CHDP Gateway, enter BIC number.   |