QUESTIONABLE RESULT

[redacted]

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST)	(FIRST)	(INITIAL)	MEDICAL RECORD NO.	I.A. Code	
DOE	JANE	A	1234567890	05	94 09446782 J

BIRTHDATE Mo. Day Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM Mo. Day Year	Ethnic Code
02 25 01	6y	F	COUNTY	19	(310)555-1212	07 01 10	6

1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

RESPONSIBLE PERSON (NAME)	(STREET)	(APT/SPACE #)	(CITY)	(ZIP)
AMY DOE	1234 OAK STREET		TOWN	90022

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM	✓				01 42.12
02 DENTAL ASSESSMENT/REFERRAL	✓				
03 NUTRITIONAL ASSESSMENT	✓				
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION	✓				
05 DEVELOPMENTAL ASSESSMENT	✓				
06 SNELLEN OR EQUIVALENT			2		06 5.04
07 AUDIOMETRIC	✓				07 11.60
08 HEMOGLOBIN OR HEMATOCRIT	✓				08 3.01
09 URINE DIPSTICK	✓				09 2.87
10 COMPLETE URINALYSIS		✓			10
12 TB MANTOUX		✓			12

DATE OF SERVICE: Mo. 07 Day 01 Year 07

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

CODE	OTHER TESTS	CODE	OTHER TESTS

PLEASE REFER TO THE CHDP LIST OF TEST CODES

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
04 8 0/4	055	05	80 %	90/60

HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT LBS	OZS
12.1	.0%		

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

06 Questionable Result (2)
20/50 OD
20/40 OS
20/50 OU

Recheck scheduled 07/26/07, 3:00 PM

ROUTINE REFERRAL(S) (✓): ☐ BLOOD LEAD ☑ DENTAL

PATIENT IS A FOSTER CHILD (✓) ☐

DIAGNOSIS CODES: 1 | 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	REFUSED OR CONTRA-INDICATED D	

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☑
2. Tobacco Used by Patient Yes ☐ No ☑
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☑ No ☐

PATIENT VISIT (✓): 1 New Patient or Extended Visit ☐ ☑ Routine Visit

TYPE OF SCREEN (✓): 1 Initial ☐ ☑ Periodic

TOTAL FEES: 64.64

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

PROVIDER NUMBER: NPINUMBER

PLACE OF SERVICE: 11

Your Facility/Provider Name
Your Street Address
City, State, 9-digit Zip Code
Your Telephone Number

1 Enrolled in WIC 2 Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY 19 AID 8W IDENTIFICATION NUMBER 54586715 6

✓ 1 ✓ If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter BIC number.

✓ 2 ✓ Patient eligible for CHDP benefits only.

This is to certify that the screening information is true and complete, and the results explained to the child or his parent or guardian. I understand that payment and satisfaction of this claim may be from Federal or State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

Examiner Signature — SIGNATURE OF PROVIDER

07/01/07 — DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

COPY 1 - MAIL TO MEDI-CAL CHDP

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (3/07)