

PATIENT HISTORY TRANSACTION

DO NOT SUBMIT CHANGES OR CLOSURES ON THIS PORTION OF FORM

REPORT OF CASE OPENED

Trans. code	State file number	Patient name	Last	First	M.I.
Birth date (month/day/year)	Sex 1—Male 2—Female 3—Unknown	Race 1—White 3—Spanish surname 5—American Indian 7—Other Nonwhite 2—Black 4—Asian 6—Filipino 8—No response 9—Unknown			
Reporting county	Residence county (if different than reporting county)				
Birth place—county or state or other country	Mother's maiden name				
Presumptive CCS	Eligible Dx				
Referral source 1—Parent 4—Other provider 7—School 2—Hospital 5—CHDP/EPST 8—DD regional center 3—Physician 6—CCS case finding 9—Other	Referral date (month/day/year)				
Disposition of case 1—Diagnosis only 3—Diagnosis and waiting list 2—Diagnosis and treatment 4—Therapy only	Completed by / date				

FILE COPY

**Changes or closures are to be made on a photocopy of this transaction!
DO NOT enter changes or closures on the original copy of this transaction!**

Notice of Change of Information
(Enter only information to be changed.)

Reopen case

Patient name 1. _____ (last)
2. _____ (first)
3. [] (m.i.)

Birth date 4. [][][][][][][][][] (month/day/year)

Sex 5. [] 1—Male 2—Female 3—Unknown

Race 6. [] 1—White 4—Asian 7—Other Nonwhite
2—Black 5—American Indian 8—No response
3—Hispanic 6—Filipino 9—Unknown

Reporting county 7. [][]

Residence county 8. [][]

Birth place 9. [][][] (county, state, or other country)

Mother's maiden name 10. _____
(last name only)

Presumptive Dx 11. a. [][][][][][][][] b. [][][][][][][][]
c. [][][][][][][][] d. [][][][][][][][]

Referral source 12. [] 1—Parent 4—Other provider 7—School
2—Hospital 5—CHDP/EPST 8—Regional center
3—Physician 6—CCS case finding 9—Other

Referral date 13. [][][][][][][][]
Month Day Year

Report of Case Closure

[][] (enter code here)

Reasons for case closure (use one only)

- 01—Treatment completed
- 02—Eligible condition cured
- 03—No treatment indicated at this time
- 04—Patient reached 21 years of age
- 05—Residence established in another county
- 06—Residence established in another state
- 07—No response at last known address
- 08—Medically ineligible
- 09—Financially ineligible
- 10—Parents will handle privately
- 11—Referred to another treatment source
- 12—Death of patient
- 13—Family covered by prepaid health plan
- 14—Unable to keep appointments
- 19—Other (specify) _____

Effective date of closure [][][][][][][][]
month day year

County [][]

Source of information _____

Completed by _____

Date _____

PRIVACY NOTIFICATION

This information is requested by the California Children's Services Program of the State Department of Health Care Services, under Section 123800 et seq. of the California Health and Safety Code, in order to provide medical treatment services. Completion of the form is required and services may be denied when not providing the information. Information will be provided to the State Department of Health Services and the county in which you reside. For more information or access to your records, contact Children's Medical Services, Program Support Section, P.O. Box 997413, MS 8100, Sacramento, CA 95899-7413; telephone (916) 327-1400.

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