

DO NOT STAPLE
IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY



PLEASE PRINT	PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.		L.A. Code	
	Mo.	BIRTH DATE Day Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER
	RESPONSIBLE PERSON (NAME)			(STREET)	(APT/SPACE #)	(CITY)	(ZIP)

CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED	REFUSED, CONTRA-INDICATED, NOT NEEDED	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE	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.
	√ A	√ B	NEW C	KNOWN D	Mo. Day Year	

01 HISTORY and PHYSICAL EXAM						01
02 DENTAL ASSESSMENT/REFERRAL						
03 NUTRITIONAL ASSESSMENT						
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION						
05 DEVELOPMENTAL ASSESSMENT						
06 SNELLEN OR EQUIVALENT						06
07 AUDIOMETRIC						07
08 HEMOGLOBIN OR HEMATOCRIT						08
09 URINE DIPSTICK						09
10 COMPLETE URINALYSIS						10
12 TB MANTOUX						

REFERRED TO:	TELEPHONE NUMBER
REFERRED TO:	TELEPHONE NUMBER

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

ROUTINE REFERRAL(S) (✓) PATIENT IS A FOSTER CHILD (✓)

BLOOD LEAD DENTAL

DIAGNOSIS CODES
1 | 2

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
0	4			
HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS
		0%		

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

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

INFORMATION ONLY REPORTING

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 (✓) New Patient or Extended Visit Routine Visit

TYPE OF SCREEN (✓) Initial Periodic

TOTAL FEES

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

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

Enrolled in WIC Referred to WIC

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

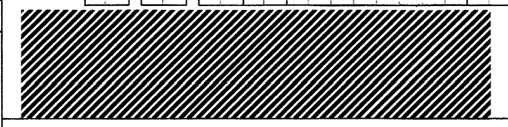
PARTIAL SCREEN SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER DATE



CONFIDENTIAL SCREENING/BILLING REPORT

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

PM 160 INFORMATION ONLY (03/07)

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

<u>POS Code</u>	<u>Description</u>
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services
Department of Health Care Services
MS 8100
1515 K Street, Suite 400
Sacramento, CA 95814

(916) 327-1400