

## Child Health and Disability Prevention Program Care Coordination / Follow-up Form

Submit to LBDHHS CHDP Administration within 5 business days of exam for children referred to a Dentist or other Medical Provider. **Do not complete this form if child is in foster care, managed care plan or private insurance.** This form only needs to be completed if problems are found during the exam. **COMPLETE FORM THEN CLICK "SUBMIT BUTTON" TO SEND VIA EMAIL.**

PATIENT INFORMATION:										
Patient Name (Last) (First) (Initial)						Preferred Language		Date of Service (MM/DD/YY)		
Birthdate (MM/DD/YY)		Age	Sex	Gender	County of Residence			Telephone # (Home or Cell) ( ) ( )		Alternate Phone # (Work or Other) ( ) ( )
Responsible Person (Name) (Street) (Apt/Space #) (City) (Zip)						<b>Ethnic Code</b> <input type="checkbox"/>		1. White 2. Hispanic/Latino 3. Black/African American 4. American Indian/Alaska Native 5. Asian 6. Native Hawaiian/Other Pacific Islander 7. Other		
Patient Eligibility	Aid Code	Identification Number (BIC)								
A. Medical Assessment and Referral Section										
Significant Medical History <input type="checkbox"/> No or Special Conditions: <input type="checkbox"/> Yes, Specify: _____					Height in inches		Weight lbs.	BMI %	Hemoglobin	
<b>CHDP ASSESSMENT</b>  Physical Exam Nutrition Developmental Vision Hearing	Problem Suspected				Referred To & Phone Number <i>Or</i> <input type="checkbox"/> Return Visit Scheduled					
	Problem Suspected				Referred To & Phone Number <i>Or</i> <input type="checkbox"/> Return Visit Scheduled					
	Problem Suspected				Referred To & Phone Number <i>Or</i> <input type="checkbox"/> Return Visit Scheduled					
	Problem Suspected				Referred To & Phone Number <i>Or</i> <input type="checkbox"/> Return Visit Scheduled					
B. Dental Assessment and Referral Section										
<input type="checkbox"/> <b>Class I:</b> No Visible Problems  <i>Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)</i>		<input type="checkbox"/> <b>Class II:</b> Visible decay, small carious lesion or gingivitis  <i>Needs non-urgent dental care</i>		<input type="checkbox"/> <b>Class III:</b> Urgent – pain abscess, large carious lesions or extensive gingivitis  <i>Immediate treatment for urgent dental condition which can progress rapidly</i>		<input type="checkbox"/> <b>Class IV:</b> Emergent – acute injury, oral infection or other pain  <i>Needs immediate dental treatment within 24 hours</i>				
Fluoride Varnish Applied: <input type="checkbox"/> Yes, applied <input type="checkbox"/> No, teeth have not erupted <input type="checkbox"/> Ordered FV, date to be applied: _____ <input type="checkbox"/> No, other reason : _____										
<input type="checkbox"/> Dental home referral Referred To & Phone Number: _____										
C. Additional Comments										
D. Referring Provider Information										
Service Location: (Office Name, Address, Telephone Number)					City of Long Beach Department of Health and Human Services Child Health & Disability Prevention Administration 2525 Grand Avenue Long Beach, CA 90815-1765  Attention: Veronica Cardenas Phone: 562-570-7980 Fax: 562-570-4099 Email: veronica.cardenas@longbeach.gov					
Provider Office NPI Number:										
Rendering Provider Name: (Print Name)										
Rendering Provider Signature: _____					Date: _____					