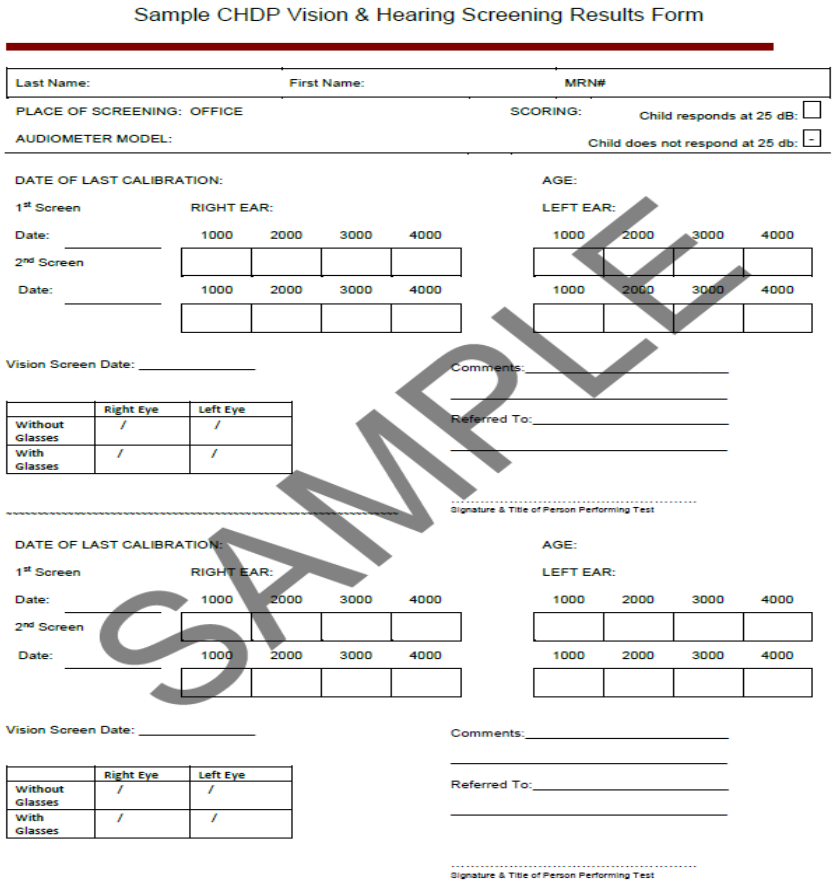
CHDP
Audiometric Documentation and Referrals

REFERRAL DOCUMENTATION AND FOLLOW UP

- If a child fails the 1st hearing screen, schedule a re-screen after six weeks
- If a child fails the 2nd hearing screen, please refer to an audiologist and submit a referral to CCS/CHDP
  - CCS/CHDP contact: phone (805) 781-5527 fax (805) 781-4492
  - Head Start: please refer child to primary care physician for further evaluation
- For children with special health care needs, please refer to an audiologist when the child cannot be screened using standard testing procedures

SCREENING DOCUMENTATION

This is an example of a CHDP Vision and Hearing screening results form. If a child does not want to respond to a certain frequency, you would just add a dash mark (-) in the appropriate box.



Sample CHDP Vision & Hearing Screening Results Form

Last Name: First Name: MRN#

PLACE OF SCREENING: OFFICE SCORING: Child responds at 25 dB: ☐

AUDIOMETER MODEL: Child does not respond at 25 db: -

DATE OF LAST CALIBRATION: AGE:

	RIGHT EAR:				LEFT EAR:			
1st Screen	1000	2000	3000	4000	1000	2000	3000	4000
Date:								
2nd Screen	1000	2000	3000	4000	1000	2000	3000	4000
Date:								

Vision Screen Date: _____

	Right Eye	Left Eye
Without Glasses	/	/
With Glasses	/	/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: AGE:

	RIGHT EAR:				LEFT EAR:			
1st Screen	1000	2000	3000	4000	1000	2000	3000	4000
Date:								
2nd Screen	1000	2000	3000	4000	1000	2000	3000	4000
Date:								

Vision Screen Date: _____

	Right Eye	Left Eye
Without Glasses	/	/
With Glasses	/	/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

SAMPLE

Source: http://www.dhcs.ca.gov/services/chdp/Documents/CHDPTrain/ReultsForm.pdf

CARE COORDINATION FORM

Since the state discontinued the use of PM 160, they have come up with a new care coordination form. This form is a way to communicate to the local CHDP program. For any fee-for-service or Gateway Medi-Cal child who has failed a hearing screen, please complete this form and send it back to the CHDP department. Our fax # is: (805) 781-4492.

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

Submit to the County CHDP Program within 5 business days of the examination - eFax: (805) 781-4492 - ATTN: REGINA SAMSON, PHN (805) 781-5558
Do not complete this form if child is in the foster care system. Health Care providers are required to submit a HCPCFC Foster Care Medical (Specialty)/ Dental Contact Form for all types of appointments. For foster children - providers only complete page 2.

Patient Name (Last)	(First)	(Initial)	Language	Date of Service (Month Day Year)
Doe, Joe			English	03 23 2018

Birthdate (Month Day Year)	Age	Sex	Gender	Patient's County of Residence	Telephone # (Home or Cell)	Alternate Phone # (Work or Other)
01 18 2013	5	M	Male	San Luis Obispo	(805) 335-3333	( )

Responsible Person (Name)	(Street)	(Apt/Space #)	(City)	(Zip)
Jane Doe	555 Maple Street		San Luis Obispo	93401

Ethnic Code: 1 (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	County	Aid Code	Identification Number	Next CHDP Exam Date (Month Day Year)
	40	P9	9722333F	05/01/2018

A. Medical Assessment and Referral Section

☐ No Medical Problems Suspected | Significant Medical History or Special Conditions: ☐ No ☒ Yes, Specify: Unspecified Hearing Loss

Physical Exam	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	Comments: Failed Hearing screening on left ear on 3/23/2018 exam.
	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
Developmental Screening	☐ Speech Delay ☐ Social/Emotional ☐ Cognitive ☐ Fine Motor Delay ☐ Gross Motor Delay ☐ Other	Referred To & Contact # Or ☐ Return Visit Scheduled	
Vision Screening	☐ Problem Suspected ☐ Not screened – rescheduling ☐ Other:	Referred To & Contact # Or ☐ Return Visit Scheduled	
Hearing Screening	☒ Problem Suspected ☐ Not screened – rescheduling ☐ Other:	Referred To & Contact # Or ☐ Return Visit Scheduled: Valley Children's Audiology Center- Madera	

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems — Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis — Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis — Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain — Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted ☐ Other reason for not applying:

☐ **Dental home referral** | **Referred To and Contact Number:**

C. Referring Provider Information

Service Location: Office Name, Address, Telephone Number	Provider Office NPI Number
Dr. Joe Moe Pediatrics	12566666
330 S. Higuera Street, San Luis Obispo. Ca. 93401	Rendering Provider Name (Print Name): Dr. Joe Moe
(805) 222-3335	Provider Signature: Dr. Joe Moe
Contact person: Cindy Lou	Date: 3/23/2018

Revised 09/2017

CCS REFERRAL FORM

For children who have failed two hearing screenings six weeks apart, they can be referred to CCS by using the CCS Referral Form.

If the child is a CenCal Health member, please submit to CenCal Health for review. For non-CenCal members, fax referral to CCS (805) 781-4492. Please include which ENT/Audiologist that you want to refer the child to.

State of California—Health and Human Services Agency

Department of Health Care Services
California Children's Services/Genetically Handicapped Persons Program

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
03/23/2018	Dr. Joe Moe	1113333

4. Address (number, street): 330 S. Higuera Street, SLO, Ca. 93401 — City — State — ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
Cindy Lou	(805) 222-3333	(805) 222-3335

Client Information

8. Client name—last: Doe, John — first — middle

9. Alias (AKA)	10. Gender	11. Date of birth (mm/dd/yy)
	■ Male ☐ Female	01/18/2013

12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number
3333333		(805) 335-3333

15. Cell phone number	16. Work phone number	17. Email address
( )	( )	

18. Residence address (number, street) *(DO NOT USE P.O. BOX)*: 555 Maple Street — City: San Luis Obispo — State: Ca. — ZIP code: 93401

19. Mailing address (if different) (number, street, P.O. box number): Same As above — City — State — ZIP code

20. County of residence	21. Language spoken	22. Name of parent/legal guardian
San Luis Obispo	English	Jane Doe

23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number
Jane	Dr. Joe Moe	(805) 222-3333

Insurance Information

26.a. Enrolled in Medi-Cal?	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
■ Yes ☐ No	97222333F	9722333F

27. Enrolled in commercial insurance plan	If yes, type of commercial insurance plan	Name of plan
☐ Yes ■ No	☐ PPO ☐ HMO ☐ Other	

Diagnosis

28. Diagnosis (DX)/ICD-10: H90.2- Conductive Hearing Loss DX/ICD-10: _____ DX/ICD-10: _____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)
04	Audiology Evaluation	3/23/2018	3/23/2019	n/a	n/a	n/a

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached	36. Enter facility name (where requested services will be performed, if other than office).
■ Yes	Valley Children's Hospital- Madera

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. Provider's name	Provider number	Telephone number	Contact person
		( )	

Address (number, street) — City — State — ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date
Dr. Joe Moe	3/23/2018

DHCS 4488 (09/15)

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PLEASE COMPLETE:

In order to receive your certificate of completion, please complete the

post-test & evaluation and submit to:

rsamson@co.slo.ca.us

For any questions, please contact the local CHDP office (805) 781-5527.

If you feel that you need a 1:1 practicum please notify us at rsamson@co.slo.ca.us so that we can schedule a day to do the practicum with you.

Thank you for participating in the County of San Luis Obispo Audiometric Training!