CHDP CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT

CHDP Health Assessment Provider:

- Retain original form in patient's medical record.
- Send photocopy to diagnosis/treatment provider.

Diagnosis/Treatment Provider:

- Complete and sign form. Retain the signed form in patient's medical record.
- If patient consent is given, send photocopy of completed and signed form to the CHDP Health Assessment Provider.
- If patient consent is given, send photocopy of completed and signed form to the local CHDP program. To find the mailing address for the local CHDP Program, go to www.dhs.ca.gov/chdp.

CHDP HEALTH ASSESSMENT PROVIDER COMPLETES THIS SECTION:

Patient name (Last) (First) (Initial) | BIC number

Date of birth (Month / Day / Year) | Sex ☐ Female ☐ Male | Patient's county of residence | Code | Telephone number

Responsible person (Name) (Street) (City) (ZIP code)

Dear _____:
(Diagnosis/Treatment Provider)

The above named patient received a CHDP health assessment on _____. The following suspected condition(s) was identified as needing further evaluation:
(Date)

1. _____

2. _____

3. _____

After you have seen and examined the patient, please note your findings below. If appropriate consent has been obtained below, please send a photocopy to me and/or the local CHDP program. Thank you,

Printed name of CHDP Health Assessment Provider | Signature | Date

Mailing Address (street, number) | City | ZIP code | ( ) Telephone number

PARENT COMPLETES THIS SECTION:

CONSENT: I have read the release of information disclosure on page 2 and I hereby authorize release of information to:

☐ Local CHDP Program ☐ CHDP Health Assessment Provider

Signature of Responsible Person | Date

DIAGNOSIS/TREATMENT PROVIDER COMPLETES THIS SECTION:

A. What was your diagnosis (ICD terminology) of **suspected condition 1**?	What was your diagnosis (ICD terminology) of **suspected condition 2**?	What was your diagnosis (ICD terminology) of **suspected condition 3**?
ICD Code *(optional)*	ICD Code *(optional)*	ICD Code *(optional)*
B. **Result of diagnosis:** *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*
☐ Abnormality not confirmed	☐ Abnormality not confirmed	☐ Abnormality not confirmed
☐ Abnormality confirmed:	☐ Abnormality confirmed:	☐ Abnormality confirmed:
☐ No treatment indicated	☐ No treatment indicated	☐ No treatment indicated
☐ Treatment indicated—given	☐ Treatment indicated—given	☐ Treatment indicated—given
☐ Treatment indicated—referred	☐ Treatment indicated—referred	☐ Treatment indicated—referred
☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred
Reason:	**Reason:**	**Reason:**

Diagnosis/Treatment Provider signature ➤ | Date examined (Month / Day / Year) | Diagnosis/Treatment Provider's telephone number ( )

RELEASE OF INFORMATION DISCLOSURE

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the recommended services. The director or the deputy director of the local CHDP program at your local health department has the responsibility to maintain this copy as a confidential record.

- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or you received the recommended services. This copy will be kept by the health assessment provider in your child's or your confidential patient file.