DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | L.A. Code

BIRTHDATE Mo. Day Year | AGE Mos. | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code
1-American Indian
2-Asian
3-Black
4-Filipino
5-Mex. Amer./Hispanic
6-White
7-Other
8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column NEW C	KNOWN D	DATE OF SERVICE Mo. Day Year / FEES
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					12

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES			CODE	OTHER TESTS

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.

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

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

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

HEMOGLOBIN | HEMATOCRIT .0% | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL (S) (√) BLOOD LEAD DENTAL | PATIENT IS A FOSTER CHILD (√)

DIAGNOSIS CODES 1 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

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

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 (✓) 1 New Patient or Extended Visit 2 Routine Visit | TYPE OF SCREEN (✓) 1 Initial 2 Periodic | TOTAL FEES

1 Enrolled in WIC ☐ Referred to WIC

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

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

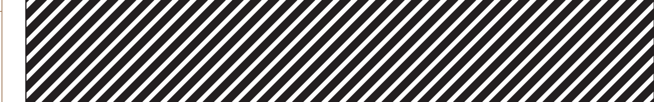
HEALTH PLAN CODE / PROVIDER NUMBER | PLACE OF SERVICE

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):



STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

SIGNATURE OF PROVIDER DATE

CONFIDENTIAL SCREENING/BILLING REPORT

COPY 1 - MAIL TO MEDI-CAL CHDP

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 INFORMATION ONLY (03/07)