

CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT PM 161 LAC

LOS ANGELES COUNTY-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP)

<http://publichealth.lacounty.gov/cms/CHDP.htm>



CHDP Referring Provider:

- Obtain consent for release of information
- Send copy of PM 160 and PM 161 to Treatment Provider
- Retain original form in patient's medical record
- Obtain referral results from Treatment Provider

Treatment Provider:

- Complete and sign form. Retain signed form in patient's medical record.
- If appropriate consent has been obtained, please return a copy to the CHDP Referring Provider and a copy to the local CHDP Program. (see page 2 and local LA County CHDP website)

I. CHDP REFERRING PROVIDER COMPLETES THIS SECTION:

Patient name (Last)	(First)	(Middle)	Date of Birth	Sex M/F	Birthplace
Address (Street)		City	Zip Code	County	Telephone Number
Responsible Person (Name)		Relationship to patient	Mother's Maiden Name		
Full Name of Father		Full Name of Mother			Telephone Number
Treatment Provider (Name/Facility)		Address			Telephone Number
Patient's Medical Record Number	Date of CHDP Physical Exam	Patient Eligibility:			
		County:	Aid:	Identification Number:	

The following suspected condition was identified as needing further evaluation (**each condition requires a separate PM 161**). Pertinent laboratory results (e.g., hemoglobin, urinalysis, blood glucose, total cholesterol, lead level, x-ray, results of vision, hearing, weight, height and PPD induration) are indicated below. A copy of the PM 160 is also attached.

After you have seen and examined the patient, please document your findings below and send a copy to the CHDP Referring Provider and to the local CHDP Program. Thank you.

Referring CHDP Provider Name (please print)		Address	City	Zip Code
Telephone Number	Fax Number	Signature of CHDP Referring Provider		Date

II. PARENT/RESPONSIBLE PERSON COMPLETES THIS SECTION:

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

<input type="checkbox"/> Local CHDP Program	<input type="checkbox"/> CHDP Referring Provider	Signature of Responsible Person	Date
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III. TREATMENT PROVIDER COMPLETES THIS SECTION:

DIAGNOSIS (I.C.D. terminology)		<input type="checkbox"/> ABNORMALITY CONFIRMED	<input type="checkbox"/> NOT CONFIRMED
Findings on initial visit:			Date
Treatment:			
Procedures:			
Referral to (e.g. CCS, Regional Center or another Consultant)			Date
Return Appointment:	Admitted to:		
PATIENT EXAMINED BY:		Telephone Number:	Physician Signature:
Physician Name (please print)			

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 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 (**CHDP Referring Provider**) to let this provider know that your child or you received the recommended services. This copy will be kept by the CHDP health assessment provider (**CHDP Referring Provider**) in your child's or your confidential patient file.