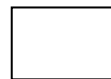


Partnership for Health Management
Quality Assurance
Database Elements



Complexity Score

Name: _____
First Last M.I.

DOB: _____ Age: _____ Sex: _____ Race/Ethnicity _____

Caregiver Name: _____ Relationship to child _____

Contact Information of Caregiver: _____
Street Address

City State County Zip Code

(____) _____ Primary Language Spoken: _____

Telephone Number with area code

Practice Name: _____ Primary Care Provider Name: _____

Chronic Diagnosis: _____

Agencies Involved: CPS, CSC, LME, CDSA, Kidspath, IEP, School

CAP, DME Supplier Home Health Other, specify

Therapies: S&L PT OT Mental Health

Specialist(s): _____

Hospitalization Yes No Diagnosis _____ Date of Service _____

Emergency Room Visit Yes No Diagnosis _____ Date of Service _____

Chronic Medication(s)

Class Code(s) _____

Guilford Child Health Social Worker Name: _____

P4HM Early Intervention Specialist Name: _____

Most Recent Well Child Visit: _____

Provider Name:

Date of Service

Care Plan: Yes No

Most recent update _____

Date

Emergency Plan: Yes No

Transportation: Yes No

Specialized Transportation: Yes No

Insurance#: _____ Type: _____