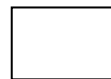


Partnership for Health Management  
Quality Assurance  
Database Elements



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: \_\_\_\_\_