PATIENT HISTORY TRANSACTION

DO NOT SUBMIT CHANGES OR CLOSURES ON THIS PORTION OF FORM

REPORT OF CASE OPENED

Trans. code	State file number	Patient name Last	First	M.I.

Birth date (month/day/year)	Sex	Race
	1—Male 2—Female 3—Unknown	1—White 2—Black 3—Spanish surname 4—Asian 5—American Indian 6—Filipino 7—Other Nonwhite 8—No response 9—Unknown

Reporting county	Residence county (if different than reporting county)

Birth place—county or state or other country	Mother's maiden name

Presumptive CCS
Eligible Dx

Referral source	Referral date (month/day/year)
1—Parent 4—Other provider 7—School 2—Hospital 5—CHDP/EPSDT 8—DD regional center 3—Physician 6—CCS case finding 9—Other	

Disposition of case	Completed by / date
1—Diagnosis only 3—Diagnosis and waiting list 2—Diagnosis and treatment 4—Therapy only	

FILE COPY

Changes or closures are to be made on a photocopy of this transaction!
DO NOT enter changes or closures on the original copy of this transaction!

☐ **Notice of Change of Information**
(Enter only information to be changed.)

☐ Reopen case

Patient name 1. _____ (last)
2. _____ (first)
3. ____ (m.i.)

Birth date 4. ____ (month/day/year)

Sex 5. ____ 1—Male 2—Female 3—Unknown

Race 6. ____ 1—White 2—Black 3—Hispanic 4—Asian 5—American Indian 6—Filipino 7—Other Nonwhite 8—No response 9—Unknown

Reporting county 7. ____

Residence county 8. ____

Birth place 9. ____ (county, state, or other country)

Mother's maiden name 10. _____ (last name only)

Presumptive Dx 11. a. ____ b. ____
c. ____ d. ____

Referral source 12. ____ 1—Parent 2—Hospital 3—Physician 4—Other provider 5—CHDP/EPSDT 6—CCS case finding 7—School 8—Regional center 9—Other

Referral date 13. ____ Month Day Year

☐ **Report of Case Closure**

____ (enter code here)

Reasons for case closure (use one only)
01—Treatment completed
02—Eligible condition cured
03—No treatment indicated at this time
04—Patient reached 21 years of age
05—Residence established in another county
06—Residence established in another state
07—No response at last known address
08—Medically ineligible
09—Financially ineligible
10—Parents will handle privately
11—Referred to another treatment source
12—Death of patient
13—Family covered by prepaid health plan
14—Unable to keep appointments
19—Other (specify) _____

Effective date of closure ____ month day year

County ____

Source of information _____

Completed by _____

Date _____

PRIVACY NOTIFICATION

This information is requested by the California Children's Services Program of the State Department of Health Care Services, under Section 123800 et seq. of the California Health and Safety Code, in order to provide medical treatment services. Completion of the form is required and services may be denied when not providing the information. Information will be provided to the State Department of Health Services and the county in which you reside. For more information or access to your records, contact Children's Medical Services, Program Support Section, P.O. Box 997413, MS 8100, Sacramento, CA 95899-7413; telephone (916) 327-1400.

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