



Partnership HealthPlan of California Pediatric Health Risk Assessment Form

Please take a few minutes to complete this form to help us learn about your child’s health and wellness needs. We want to use these answers to help you get the right care as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the green envelope

To: Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership CCS Member: _____

Date of Birth: _____

Medi-Cal ID Number: _____

1. Who is answering the questions on this survey?

- Mother Father Grandparent Foster Parent Self
- Other Family Member: _____ Other: _____

2. What is your preferred language?

- English Spanish Tagalog Russian Other: _____

3. Does your child have difficulty with any of the following? (Choose N/A if you would not expect other children of this age to be able to do this on his/her own)

Taking care of him/herself, such as:

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Feeding him/herself (feeding) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Taking a bath or shower (bathing) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Getting dressed (dressing) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Going to the toilet (toileting) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Making it to the toilet on time/without an “accident” (continence) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

Being active, like:

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Walking (mobility) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Getting out of a bed or a chair (transferring) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Going up or down stairs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

Showing independence by:

- | | | | |
|---------------------------------------|------------------------------|-----------------------------|------------------------------|
| Going out to visit family or friends | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Going to school or work | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Making doctor or dentist appointments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Using the phone, tablet, or computer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? Yes No Not sure
What is the name of the center where you go? _____

5. Does your child receive any of the following services? (Check all that apply)
- Speech Therapy
Where is this received? Home School Medical Therapy Program (MTP) or Medical Therapy Unit (MTU)
Other _____
 - Physical Therapy
Where is this received? Home School MTP/MTU
Other _____
 - Occupational Therapy
Where is this received? Home School MTP/MTU
Other _____
 - Respiratory Therapy
Where is this received? Home School
Other _____
 - Nursing Services
Where is this received? Home School Hours/days per week? _____
Other _____
 - Mental or Behavioral Therapy
Where is this received? Home School
Other _____
 - Individualized Education Plan (IEP) or 504 Plan or other learning support?
Which one(s)? IEP 504
School Name _____
 - Other supportive services (Respite Care, Palliative Care, etc.)
Please explain _____
Where is this received? Home School
Other _____

6. In general, would you say that your child's health is
Excellent Very Good Good Fair Poor

7. Does your child have any allergies?
- Food(s) (please specify) _____
Environmental (seasonal, dust, pollution, etc.) (please specify) _____
 - Medication(s) (please specify) _____
 - No Known Allergies

8. Does your child use durable medical equipment (DME) or supplies that were ordered for your child's specific needs?

Yes (check all that apply)

- Glasses
- Hearing Aids
- Cochlear Implant
- Wheelchair
- Brace
- Orthotics
- Walker
- Car Seat
- Bed
- Ventilator/breathing machine
- Oxygen
- Percussion Vest
- Insulin Pump/Continuous Glucose Monitor
- Intravenous pump/Infusion device
- Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/Gastrojejunostomy Tube (GJT)
- Other (please specify) _____

Who ordered it? _____

Date of last order _____

Who was the vendor? _____

Vendor Phone: _____

9. What is your child's current: Height _____ Weight _____

10. Has your child ever had surgery?

Yes No Don't Know

Please list each surgery

Date or Year

Please list each surgery	Date or Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list each surgery

Date or Year

More than can fit here

11. Has your child been to the emergency room (ER) in the last 6 months?

Yes No Don't know

i. How many times? _____

ii. When? _____

12. Has your child been in the hospital overnight in the last 6 months?

Yes No Don't know

i. How many times? _____

ii. When? _____

13. What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. **Start with the medications your child is taking now, and then add medications your child has taken in the past.**

Medication/Vitamin/Supplement Name	Current	Past
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
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_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> More than can fit here	<input type="checkbox"/>	<input type="checkbox"/>

14. Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past.

	Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Ventilator Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Conditions	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Para/Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Other Neurological Conditions	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Broken bone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Other bone or muscle disorders	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Ostomy/G Tube /Colostomy/Urostomy	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other gastrointestinal (GI)/stomach/digestion conditions	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Other Blood Conditions	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
Is your child on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Conditions, i.e. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Growth / Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
Underweight / Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraines / Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Poisoning	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
What is/are the conditions(s)?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

15. Does your child need a specialist to provide care for any of these conditions?

- Yes
 - Which condition(s) _____
- No – my child already has provider(s) for all his/her needs
 - Name/Specialty _____
 - Name/Specialty _____
 - Name/Specialty _____
- No – my child does not need a specialist for his/her condition

16. Who are your child's medical providers?

Primary Care Provider (PCP) in your community

- Do not have one
- Provider Name: _____
- Provider Phone: _____
- Last Appointment: Date: _____
- Next Appointment: Date: _____

Specialty Care Center

- N/A
- Facility Name: _____
- Facility Phone: _____
- Last Appointment: Date: _____
- Next Appointment: Date: _____

Regular Dental Care

- Do not have one
- Provider Name: _____

Provider Phone: _____

Last Appointment: Date: _____

Regular Vision Care

Do not have one

Provider Name: _____

Provider Phone: _____

Last Appointment: Date: _____

Ongoing care from Mental or Behavioral Health Specialist

N/A

Provider Name: _____

Provider Phone: _____

Condition(s) being treated for: _____

My child does not get regular care from any provider

Do you need help choosing a provider for your child?

Yes No Don't know

17. Have your child's medical conditions caused him/her to miss activities, work, or school in the past year?

If yes, please describe:

18. What is the best time of day (Monday to Friday, 7:30 a.m. to 5:30 p.m.) to call you to discuss your child's needs in more detail?

Signature of Person

Filling Out the Form: _____ Date: _____

Thank you for your time filling out this form.

CONFIDENTIAL