



# 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:** \_\_\_\_\_

- Who is answering the questions on this survey?
  - Mother    Father    Grandparent    Foster Parent    Self
  - Other Family Member: \_\_\_\_\_    Other: \_\_\_\_\_
  
- What is your preferred language?
  - English    Spanish    Tagalog    Russian    Other: \_\_\_\_\_
  
- 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**

<b>Please list each surgery</b>	<b>Date or Year</b>



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

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

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