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)	☐Yes	☐No	☐N/A
Taking a bath or shower (bathing)	☐Yes	☐No	☐N/A
Getting dressed (dressing)	☐Yes	☐No	☐N/A
Going to the toilet (toileting)	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident" (continence)	☐Yes	☐No	☐N/A
Being active, like:			
Walking (mobility)	☐Yes	☐No	☐N/A
Getting out of a bed or a chair (transferring)	☐Yes	☐No	☐N/A
Going up or down stairs	☐Yes	☐No	☐N/A
Showing independence by:			
Going out to visit family or friends	☐Yes	☐No	☐N/A
Going to school or work	☐Yes	☐No	☐N/A
Making doctor or dentist appointments	☐Yes	☐No	☐N/A
Using the phone, tablet, or computer	☐Yes	☐No	☐N/A
Other _____	☐Yes	☐No	☐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
☐ **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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
More than can fit here	☐	☐

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

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

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.
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