REFERRAL FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

Case Name _____

Case Number _____

List all family members under 21 years of age (first & last name)	Accepts Screening: Preferred Source			Refuses Screening Reasons		
	A	B	C	D	F	G
	Physician (Includes MediPASS physician)	Child Health Center	Continuing Care Provider*	Child has received an EPSDT screen according to periodicity schedule	Religious or personal beliefs	Other, Explain
Person Name State I.D.						
Person Name State I.D.						
Person Name State I.D.						
Person Name State I.D.						
Person Name State I.D.						
Person Name State I.D.						

If a person under age 21 is added to the case, note the response from the family.

Is assistance with transportation or appointments or other services needed to obtain screening? ❑ Yes ❑ No

If yes, explain_____

The benefits, services and advantages of the screening program have been explained to the client with the decision noted above. Written material explaining the EPSDT program was provided to the client.

Worker's Signature	Date

*The benefits and advantages of a continuing care provider have been explained to the client. The client agrees to use one continuing care provider (HMO) as the regular source of EPSDT services for the period of enrollment in the HMO.

Signature of Worker	Date

Remarks: _____

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