10. MEDICAL CARE STANDARDS

A. Initial Health Assessment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members and Providers.

POLICY:

A. IEHP Members are notified of the availability and need for their Primary Care Physician (PCP) to schedule and conduct the Initial Health Assessment (IHA) within:
   1. Sixty (60) calendar days of enrollment for Members under 18 months of age; or
   2. One hundred twenty (120) calendar days of enrollment for Members age 18 months and older.

B. All Members must receive the Staying Healthy Assessment (SHA) as part of their IHA. See Policy 15F, “Individual Health Education Behavioral Assessment (IHEBA) and Staying Healthy Assessment (SHA)” for more information on administering SHAs.

C. PCPs are required to have processes in place to notify and facilitate access to IHAs for Members.

D. IEHP requires that PCPs maintain documentation of all attempts to inform Member of the need for an IHA.

E. IEHP requires PCPs to adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF) for preventive services for asymptomatic healthy adults with a focus on Grade A and B USPSTF recommendations. Current USPSTF Grade A and B Recommendations can be found online at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

F. IEHP requires that PCPs provide preventive services for Members under age 21 as specified by the most recent American Academy of Pediatrics (AAP) and/or Child Health and Disability Prevention (CHDP) Program age-specific guidelines. These services must be delivered according to the current AAP/Bright Futures periodicity schedule and guidelines (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf).

DEFINITION:

A. Initial Health Assessment – This consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables the PCP to comprehensively assess the Member’s current acute, chronic and preventive health needs. Please see Policy 15F, “Individual Health Education Behavioral Assessment” for more information on IHEBA.

PROCEDURES:

A. An IHA consists of the following components:
10. MEDICAL CARE STANDARDS

A. Initial Health Assessment

1. History of present illness.
2. Behavioral history - review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc.;
3. Review of past medical and social history;
4. Review of systems - review of signs and symptoms related to all major organ systems;
5. Review of current medication use;
6. Review of preventive services - review of status of Member in terms of needed preventive services (e.g., immunizations, cervical cancer screening). The needed preventive services should either be provided on the day the IHA is performed, or additional visits should be scheduled to provide them;
7. Physical exam (including mental status) sufficient to assess the Member’s acute, chronic, preventive health needs, and psychosocial needs;
8. Dental screening/oral health assessment – for Members under 21 years of age, annual dental referrals must be made no later than 12 months of age or when referral is indicated based on assessment;
9. Diagnostic tests - ordering of appropriate diagnostic tests, as needed; and
10. Development of Problem List and Medication List, if appropriate.

B. Specific components of health assessments are also found in Policies 10B, “Adult Preventive Services” and 10C1 through 10C3, “Pediatric Preventive Services.”

C. PCPs are responsible for informing Members of the need for an IHA. PCPs may work in collaboration with their IPA in meeting this requirement.

D. PCPs are responsible for assessing Medi-Cal Members of the need for, and scheduling of, if necessary, an IHA at any time they see the Member for an acute or chronic illness visit prior to performing the IHA. If the Member has had a comprehensive health assessment within twelve (12) months, the PCP must document the specifics in the medical record.

E. PCPs are responsible for follow-up of missed appointments, as outlined in Policy 9B, “Missed Appointments” for the IHA for Medi-Cal Members.

F. PCPs are responsible for arranging follow-up visits or referrals for Medi-Cal Members that have significant health problems identified during the IHA.

G. Providers can view a current list of their Members eligible for an IHA by accessing the IEHP secure Provider Portal.

H. PCPs are required to have specific policies in place regarding the notification of Members about the sixty (60) and one hundred twenty (120) calendar day IHA. PCP documentation (i.e., letters to all Members, active or not, informing them of the need for an IHA) needs to be maintained by the PCP office for a minimum of ten (10) years. If the Member does access care and a chart is opened, the notification must be filed in the Member’s chart and maintained
10. MEDICAL CARE STANDARDS

A. Initial Health Assessment

according to Policy 7A, “PCP and IPA Medical Record Requirements.” If the Member never accesses care with the PCP, the office must still maintain the documentation according to Policy 7A noted above.

I. Exceptions from IHA requirements and other information can be found in the DHCS-MMCD Policy Letter No. 08-003 found at: www.dhcs.ca.gov/formsandpubs/documents/mmcadaplsandpolicyletters/pl%202008/PL08-003.pdf

REFERENCES:

A. Department of Health Care Services (DHCS) Policy Letter (PL) 08-003, “Initial Comprehensive Health Assessment”

B. DHCS Final Rule Contract Amendment January 2018, Exhibit A, Attachment 10, Scope of Services

C. DHCS All Plan Letter (APL) 19-010 Supersedes APL 18-007 and 07-008, “Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21”.

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file | Original Effective Date: September 1, 1996

Chief Title: Chief Medical Officer | Revision Date: January 1, 2019

IEHP Provider Policy and Procedure Manual 01/19
Medi-Cal MC_10A Page 3 of 3
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. For Members 18 years of age and older, Primary Care Physicians (PCPs) are required to deliver Adult Preventive Services consistent with the most recent edition of the United States Preventive Services Task Force (USPSTF) guidelines, unless specified differently by IEHP. According to the USPSTF, services with a grade of “A” or “B” are recommended to be offered or provided.

B. If a Member does not receive the appropriate services as required, the PCP must document attempts made to contact the Member and the Member’s non-compliance.

C. In accordance with State and Federal standards IEHP requires all IEHP network Physicians to provide immunization services according to the most recent U.S. Public Health Service’s Advisory Committee on Immunization Practice (ACIP) recommendations, regardless of the Member’s age, sex, or medical condition, including pregnancy. When the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers are to administer immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

D. Pursuant to State requirements, Medi-Cal Member can access immunization services through Local Health Department (LHD) immunization clinics.

E. Immunizations are preventive services not subject to prior authorization requirements.

PROCEDURES:

Health Assessments

A. PCPs are required to provide an Initial Health Assessment (IHA) within one hundred twenty (120) days of enrollment to all Medi-Cal Members assigned to them as outlined in Policy 10A, “Initial Health Assessment.”

B. PCPs are required to provide targeted history and physical examinations focused on the needs and risk factors of Members on an annual basis.

C. History and physical examinations must include, at a minimum:
   1. Comprehensive (initial) or interim medical history including history of illness, injury, family history, etc;
   2. Staying Healthy Assessment (SHA) using the age appropriate “Staying Healthy Assessment” tool as outlined in Policy 15F, “Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA)”;

   Physical exam - Either comprehensive (initial) or targeted (interim) addressing all
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

appropriate parts of the body and organ systems, including screening for high blood pressure, pulse, respiratory rate, temperature, height and weight, and BMI;

a. The Staying Healthy Assessment (SHA) includes screening questions regarding Member’s smoking status and/or exposure to tobacco smoke.

b. Members are to be annually assessed on their tobacco use status, unless an assessment needs to be re-administered based on the Staying Healthy Assessment’s periodicity schedule.
   1) Providers are to review the questions on tobacco with the Member. This constitutes as individual counseling.

c. Providers are required to ask Members about their current tobacco use and document this information in their medical record at every visit.

3. Dental screening – An oral survey for teeth, gum or oral cavity related illnesses or injuries; and

4. Vision and hearing screening as appropriate for age.

D. With regards to Members identified as using tobacco products. IEHP encourages Providers to implement the following interventional approach:

1. Providers are encouraged to use a validated behavior change model to counsel Members who use tobacco products. Examples include the following which can be found in the Provider Training Material, which can be requested through Providers Services or available online on the Provider Portal:
   a. Use of the “5 A’s” – Ask, Advise, Assess, Assist, and Arrange.
   b. Use of the “5 R’s” – Relevance, Risks, Rewards, Roadblocks, and Repetition.

2. Members are able to receive a minimum of four (4) counseling sessions of at least ten (10) minutes/session. Members may choose individual or group counseling conducted in person or by telephone.
   a. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

3. Two (2) quit attempts per year are covered without prior authorization and there are no mandatory breaks between quit attempts.
   a. Current Procedure Terminology and ICD codes for tobacco use are available on the Provider Training Material, which can be requested through Providers Services or available online on the Provider Portal.

4. Members are to be referred to the California Smoker’s Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

the Helpline’s web referral, or if available in their area, the Helpline’s e-referral system.

5. Providers are strongly encouraged to implement the recommendations from the U.S. Department of Health and Human Services Public Health Services (USPHS) “Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update.” This document is accessible at: https://bphc.hrsa.gov/buckets/treatingtobacco.pdf

E. IEHP understands that in certain cases Members do not come in for the physical exams for reasons beyond their PCP’s control. PCPs are therefore, expected to make reasonable efforts to schedule the examinations for their assigned Members on an episode basis. For Members that they have never seen, PCPs are required to actively outreach to Members when they first enroll to schedule the one hundred twenty (120) days Initial Health Assessment. See Policy 10A, “Initial Health Assessment.” Below are the USPSTF Grade A or B Recommendations as of May 2018:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Year</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm (AAA)</td>
<td>Screening</td>
<td>2014</td>
<td>All men 65-75 who ever smoked should receive a one-time screening for AAA by ultrasonography.</td>
<td>B</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>Screening, Counseling</td>
<td>2013</td>
<td>Screen adults aged 18 or older, including pregnant women, for alcohol misuse and provide appropriate behavioral counseling.</td>
<td>B</td>
</tr>
<tr>
<td>Aspirin Preventive Medication</td>
<td>Intervention</td>
<td>2016</td>
<td>All Members ages 50-59 should use low-dose aspirin for the primary prevention of cardiovascular disease (CVD) and colorectal cancer if they meet the following criteria: ≥10% ten (10)-year CVD risk, no increased risk of bleeding, life expectancy of at least ten (10) years, and are willing to take low-dose aspirin daily for at least ten (10) years.</td>
<td>B</td>
</tr>
<tr>
<td>Bacteriuria Screening: pregnant women</td>
<td>Screening</td>
<td>2008</td>
<td>Pregnant women should be screened for asymptomatic bacteriuria with urine culture at twelve (12) to sixteen (16) weeks’ gestation or the first prenatal visit, if later.</td>
<td>A</td>
</tr>
<tr>
<td>Blood Pressure Screening in Adults</td>
<td>Screening</td>
<td>2015</td>
<td>Screen adults 18 years or older and obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment.</td>
<td>A</td>
</tr>
<tr>
<td>BRCA Risk Assessment</td>
<td>Screening, Counseling, Intervention</td>
<td>2013</td>
<td>Screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to</td>
<td>B</td>
</tr>
</tbody>
</table>
### 10. MEDICAL CARE STANDARDS

#### B. Adult Preventive Services

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Year</th>
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<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Preventive Medications</td>
<td>Intervention</td>
<td>2013</td>
<td>For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.</td>
<td>B</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Screening</td>
<td>20016</td>
<td>All women aged 50-74 years should receive biennial screening mammography.</td>
<td>B</td>
</tr>
<tr>
<td>Breastfeeding Counseling</td>
<td>Intervention</td>
<td>2016</td>
<td>Interventions during pregnancy and after birth should be initiated to promote and support breastfeeding.</td>
<td>B</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Screening</td>
<td>2012</td>
<td>Cervical cancer screening is recommended for women ages 21-65 years with cytology (Pap smear) every 3 years or, for women ages 30-65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>A</td>
</tr>
<tr>
<td>Chlamydia Screening: women</td>
<td>Screening</td>
<td>2014</td>
<td>Screen all sexually active females age 24 years or younger and in older women who are at increased risk for infection.</td>
<td>B</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Screening</td>
<td>2016</td>
<td>Colorectal cancer screening should be offered to all adults starting at age 50 and continuing until age 75 years. The risks and benefits of different screening methods vary and specific screening strategies are left to the determination of the treating physician.</td>
<td>A</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Screening</td>
<td>2016</td>
<td>Screen all adults, including pregnant and postpartum women, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
<td>B</td>
</tr>
<tr>
<td>Diabetes Screening</td>
<td>Screening</td>
<td>2015</td>
<td>Screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40-70 years who are overweight or obese.</td>
<td>B</td>
</tr>
</tbody>
</table>
## 10. MEDICAL CARE STANDARDS

### B. Adult Preventive Services

<table>
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</thead>
<tbody>
<tr>
<td>Glucose abnormalities can be detected by</td>
<td>Counseling, Intervention</td>
<td>2018</td>
<td>Exercise interventions to prevent falls is recommended in community-dwelling adults age 65 years and older who are at increased risk of falls.</td>
<td>B</td>
</tr>
<tr>
<td>Fall Prevention in Older Adults</td>
<td>Counseling, Intervention</td>
<td>2018</td>
<td>Exercise interventions to prevent falls is recommended in community-dwelling adults age 65 years and older who are at increased risk of falls.</td>
<td>B</td>
</tr>
<tr>
<td>Folic Acid Supplementation</td>
<td>Intervention</td>
<td>2017</td>
<td>All women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8mg (400 to 800 µg) of folic acid.</td>
<td>A</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.</td>
<td>B</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk of infection.</td>
<td>B</td>
</tr>
<tr>
<td>Healthy Diet &amp; Physical Activity Counseling to</td>
<td>Counseling</td>
<td>2014</td>
<td>Offer or refer adults who are overweight or obese and have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.</td>
<td>B</td>
</tr>
<tr>
<td>prevent Cardiovascular Disease (CVD)</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for Hepatitis B virus infection in persons at high risk of infection.</td>
<td>B</td>
</tr>
<tr>
<td>Hepatitis B Screening: Adults</td>
<td>Screening</td>
<td>2009</td>
<td>Screen for Hepatitis B virus infection in pregnant women at their first prenatal visit.</td>
<td>A</td>
</tr>
<tr>
<td>Hepatitis C Virus Screening: Adults</td>
<td>Screening</td>
<td>2013</td>
<td>Screen for Hepatitis C virus (HCV) infection in persons at high risk for infection. A one-time screening for HCV infection is recommended for adults born between 1945 and 1965.</td>
<td>B</td>
</tr>
</tbody>
</table>
## 10. MEDICAL CARE STANDARDS

### B. Adult Preventive Services

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<tr>
<th>Topic</th>
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<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Screening: Adults and Pregnant Women</td>
<td>Screening</td>
<td>2013</td>
<td>Screen for HIV infection in Adults age 18 to 65 years. Older adults who are at increased risk should also be screened. Also screen all pregnant women, including those who present in labor who are untested and whose HIV status is unknown.</td>
<td>A</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>Screening, Intervention</td>
<td>2013</td>
<td>Screen women of childbearing age for intimate partner violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>B</td>
</tr>
<tr>
<td>Lung Cancer Screening</td>
<td>Screening</td>
<td>2013</td>
<td>Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</td>
<td>B</td>
</tr>
<tr>
<td>Obesity Screening &amp; Counseling</td>
<td>Screening, Counseling</td>
<td>2012</td>
<td>Screen all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions</td>
<td>B</td>
</tr>
<tr>
<td>Osteoporosis Screening: Women</td>
<td>Screening</td>
<td>2012</td>
<td>Screen for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.</td>
<td>B</td>
</tr>
<tr>
<td>Perinatal Depression</td>
<td>Intervention, Counseling</td>
<td>2019</td>
<td>Recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions</td>
<td>B</td>
</tr>
<tr>
<td>Preeclampsia Prevention: Aspirin</td>
<td>Intervention</td>
<td>2014</td>
<td>Use low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia.</td>
<td>B</td>
</tr>
</tbody>
</table>
### B. Adult Preventive Services

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Preeclampsia Screening</strong></td>
<td>Screening</td>
<td>2017</td>
<td>Pregnant Members are to be screened for preeclampsia with blood pressure measurements throughout pregnancy.</td>
</tr>
<tr>
<td><strong>Rh Incompatibility Screening: 1st Pregnancy Visit</strong></td>
<td>Screening</td>
<td>2004</td>
<td>Strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
</tr>
<tr>
<td><strong>Rh Incompatibility Screening: 24-28 weeks’ gestation</strong></td>
<td>Screening</td>
<td>2004</td>
<td>Recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infections Counseling</strong></td>
<td>Counseling</td>
<td>2014</td>
<td>Provide intensive behavioral counseling for all sexually active adults who are at increased risk for sexually transmitted infections.</td>
</tr>
<tr>
<td><strong>Skin Cancer Behavioral Counseling</strong></td>
<td>Counseling</td>
<td>2018</td>
<td>Counsel young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce risk for skin cancer.</td>
</tr>
<tr>
<td><strong>Statin Preventive Medication: adults ages 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater</strong></td>
<td>Intervention</td>
<td>2016</td>
<td>Adults without a history of cardiovascular disease (CVD) use a low to moderate dose statin for the prevention of CVD events and mortality when all the following are met: 1) ages 40-75; 2) 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, smoking); and 3) they have a calculated 10-year risk of CVD event of 10% or greater.</td>
</tr>
<tr>
<td><strong>Tobacco Use Counseling and Interventions: Nonpregnant Adults</strong></td>
<td>Counseling, Intervention</td>
<td>2015</td>
<td>Ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Year</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use Counseling and Interventions:</td>
<td>Counseling,</td>
<td>2015</td>
<td>Ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.</td>
<td>A</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Screening: Nonpregnant Adults</td>
<td>Screening</td>
<td>2016</td>
<td>Screen for syphilis infection in all adults who are at increased risk for infection.</td>
<td>A</td>
</tr>
<tr>
<td>Syphilis Screening: Pregnant Women</td>
<td>Screening</td>
<td>2009</td>
<td>Screen all pregnant women for syphilis infection.</td>
<td>A</td>
</tr>
<tr>
<td>Tuberculosis screening in adults</td>
<td>Screening</td>
<td>2016</td>
<td>Screen for latent tuberculosis infection in populations at increased risk.</td>
<td>B</td>
</tr>
</tbody>
</table>

**USPSTF GRADE DEFINITIONS – AFTER JULY 2012**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service for selected patients depending on individual circumstances.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends</td>
<td>Discourage the use of this</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

<table>
<thead>
<tr>
<th>I Statement</th>
<th>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
</tr>
</tbody>
</table>

F. Immunizations

1. All Members must be assessed for and receive, if indicated, immunizations according to State and Federal standards. Immunizations are provided to all Members according to the most recent U.S. Public Health Service’s Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. In instances, where the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers will provide immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

2. Immunizations are preventive services not subject to prior authorization requirements.

3. Members may access local health departments (LHDs) for immunizations. IEHP will reimburse LHDs for the immunization administration fee.

4. IEHP requires network Providers to document each Member’s need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:
   a. Illness, care management, or follow-up appointments
   b. Initial Health Assessments (IHAs)
   c. Pharmacy services
      1) Adult Members may receive vaccines through three (3) options, without a Prior Authorization (PA):
         • Vaccination from a licensed medical Provider;
         • Vaccination from a pharmacy in the Vaccine Network; and
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

- Vaccination from a Local Health Department.

2) IEHP’s contracted Pharmacy Benefit Manager (PBM) accepts vaccine administration claims from participating pharmacies in the National Council for Prescription Drug Programs (NCPDP) approved format.

d. Prenatal and postpartum care

e. Pre-travel visits

f. Sports, school, or work physicals

g. Visits to a LHD

h. Well patient checkups

5. Providers must periodically report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR). Reports must be made after a Member’s IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within fourteen (14) days of administration.
10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

REFERENCES:

http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

B. U.S. Preventive Services Task Force (USPSTF). 
http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

C. U.S. Preventative Services Task Force (USPSTF) A and B Recommendations (as of February 2019). 
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

D. Centers for Disease Control (CDC) Adult Immunization Schedule. 
https://www.cdc.gov/vaccines/schedules/index.html

E. Department of Health Care Services (DHCS), All Plan Letter (APL) 16-014, Supersedes PL 14-006, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries.

F. Department of Health Care Services (DHCS), All Plan Letter (APL) 18-004, Supersedes PL 96-013 and APL 07-015, Immunization Requirements.
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   1. Well Child Visits

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and Providers.

POLICY:

A. IEHP requires all Primary Care Physicians (PCPs) in the network to meet American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practice (ACIP), and Child Health and Disability Prevention (CHDP) guidelines (Medi-Cal only) for providing pediatric preventive services. When applicable, IEHP will also use the latest recommendations from the U.S. Preventive Services Task Force (USPSTF).

PROCEDURE:

A. Health Assessments

1. IEHP requires its contracted PCPs to provide periodic health assessments according to the Recommendations for Preventive Pediatric Health Care that is based on the consensus statement from the AAP and Bright Futures (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). PCPs must complete the various components of the assessment according to the schedule, or more frequently as the Member’s health status dictates.

2. The periodic health assessment must include the elements outlined by the Bright Futures/AAP recommendations. These elements include, but are not limited to:
   a. Comprehensive health and developmental history (including assessment of both physical and mental health development);
   b. Developmental screening tests should be performed with a validated instrument and administered at the well-child visit at 9, 18, and 30 months of age. Standardized screening tools are available to California Providers for purchase at a discounted rate (See Attachment, “Developmental Screening Tests at Discounted Rate” in Section 10);
   c. Unclothed physical examination with suitable draping for older children, including assessment of physical growth;
   d. Body Mass Index (BMI);
   e. Visual acuity screen is recommended annually at age 4 and 5 years, as well as in cooperative 3-year old;
   f. Dental risk assessment and education to parents about oral health. Dental screening/oral health assessment is included as part of the initial health assessment and then periodically thereafter according to the Dental Periodicity Schedule (See
10. MEDICAL CARE STANDARDS

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Attachment, “Periodicity Schedule – Dental” in Section 10). For more information about the initial health assessment, please see Policy_10A, “Initial Health Assessment.” Dental Assessments must include documentation in the medical record about the condition/findings of the mouth, teeth and gums;

1) Dental caries prevention – Prescribe oral fluoride supplementation starting at age 6 months through age 16 for children where water supply is deficient in fluoride.

2) Dental caries prevention – Apply fluoride varnish to primary teeth of infant and children starting at the age of primary tooth eruption and repeat every three (3) to six (6) months.

g. Hearing screening;

h. Blood Pressure screening ages 3 and older at each Well-Child visit and when clinically appropriate;

i. Immunizations are to follow ACIP recommendations necessary to make status current, as outlined in Policy 10C2, “Pediatric Preventive Services - Immunization Services”. Immunizations are preventive services not subject to prior authorization requirements.

1) Members may access local health departments (LHDs) for immunizations. IEHP will reimburse LHDs for the immunization administration fee.

2) IEHP requires network Providers to document each Member’s need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:

- Illness, care management, or follow-up appointments
- Initial Health Assessments (IHAs)
- Pharmacy services
- Prenatal and postpartum care
- Pre-travel visits
- Sports, school, or work physicals
- Visits to a LHD
- Well patient checkups

3) In instances where the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers will provide immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

4) Providers must periodically report Member-specific immunization information.
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...to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR2). Reports must be made after a Member’s IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within 14 days of administration.

j. Tuberculin test as indicated;

k. Testing for anemia when appropriate;

l. Lead testing per the California Department of Public Health’s Childhood Lead Poisoning Branch Prevention Branch recommendations [https://www.cdph.ca.gov/programs/CLPPB/Pages/default.aspx].

1) This includes oral or written guidance to the parent or guardian of a child 6 – 72 months of age that includes, at a minimum, the information that children can be harmed by exposure to lead. Anticipatory guidance shall be performed at each periodic health assessment until 72 months of age.

2) Blood lead level (BLL) testing is required as per the recommendations:

- At 12 months and at 24 months of age;
- When the health care Provider is performing a periodic health assessment, becomes aware that a child 12 to 24 months of age has no documented evidence of BLL test results taken at 12 months of age or thereafter;
- When the health care Provider is performing a periodic health assessment, becomes aware that a child 24 to 72 months of age has no documented evidence of BLL tests results taken when the child was 24 months of age or thereafter;
- Whenever the health care Provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgement of the Provider; or
- When requested by the parent or guardian.

3) Blood lead level screenings may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All confirmatory and follow-up BLL testing must be performed using blood samples taken through the venous blood sampling method.

4) Health Care Providers are not required to perform a BLL Screening if:

- Parent/Guardian refuses to consent to screening; and/or
10. MEDICAL CARE STANDARDS

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- In the Provider’s professional judgement, the screening poses a greater risk to the child’s health than the risk of lead poisoning.
- Reasons for not screening must be documented in the child’s medical record. Providers must report all blood lead screening results electronically to the California Department of Public Health Childhood Lead Poisoning Prevention Branch (CLPPB).

m. Cholesterol – Screen children ages 2-21 years with risk factors and conduct universal screening at ages 9-11 and 17-21 years. Physicians can use a non-HDL cholesterol test that does not require children to fast, and children with abnormal results should be followed up with a fasting lipid profile.

n. Screen for type 2 diabetes and pre-diabetes beginning at age 10 years or onset of puberty, and test every three (3) years using A1C with children who are overweight with two (2) or more risk factors (American Diabetes Association);

o. Hepatitis B – Screen adolescents at high risk for Hepatitis B infection and all pregnant women at their 1st prenatal visit.

USPSTF A and B Recommendations for Children and Adolescents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Year</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteriuria screening: pregnant women</td>
<td>Screening</td>
<td>2008</td>
<td>Pregnant females should be screened for asymptomatic bacteriuria with urine culture at 12-16 weeks’ gestation or the first prenatal visit, if later.</td>
<td>A</td>
</tr>
<tr>
<td>Breastfeeding Counseling</td>
<td>Counseling</td>
<td>2016</td>
<td>Interventions during pregnancy and after birth should be initiated to promote and support breastfeeding.</td>
<td>B</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>Screening</td>
<td>2014</td>
<td>Screen all sexually active females 24 years of age and younger.</td>
<td>B</td>
</tr>
</tbody>
</table>
| Dental Caries Prevention: Infants and Children up to Age 5 Years | Intervention | 2014 | • Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.  
• Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. | B |
| Depression in Children and Adolescents: Screening | Screening | 2016 | Screen for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. | B |

1 Department of Health Care Services (DHCS) all Plan Letter (APL) 18-017 supersedes Policy Letter (PL) 02-01, “Blood Lead Screening of Young Children.”
### 10. MEDICAL CARE STANDARDS

#### C. Pediatric Preventive Services

1. Well Child Visits

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
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<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folic Acid Supplementation</td>
<td>Intervention, Counseling</td>
<td>2017</td>
<td>All women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8mg (400 to 800 µg) of folic acid.</td>
<td>A</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation</td>
<td>B</td>
</tr>
<tr>
<td>Gonorrhea Prophylactic Medication: Newborns</td>
<td>Intervention</td>
<td>2019</td>
<td>Use prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.</td>
<td>A</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gonorrhea in sexually active females age 24 years and younger.</td>
<td>B</td>
</tr>
<tr>
<td>Hemoglobinopathies screening: newborns</td>
<td>Screening</td>
<td>2007</td>
<td>Screen for sickle cell disease in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>Hepatitis B Screening: Nonpregnant Adolescents</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for Hepatitis B virus infection in persons at high risk of infection.</td>
<td>B</td>
</tr>
<tr>
<td>Hepatitis B Screening: Pregnancy</td>
<td>Screening</td>
<td>2009</td>
<td>Screen for Hepatitis B virus infection in pregnant females at their first prenatal visit.</td>
<td>A</td>
</tr>
<tr>
<td>HIV Screening: Nonpregnant Adolescents</td>
<td>Screening</td>
<td>2013</td>
<td>Screen for HIV infection in nonpregnant adolescents and adults age 15 to 65 years old. Younger ages who are at increased risk should also be screened.</td>
<td>A</td>
</tr>
<tr>
<td>HIV Screening: Pregnancy</td>
<td>Screening</td>
<td>2013</td>
<td>Screen all pregnant females for HIV, including those who present in labor who are untested and whose HIV status is unknown.</td>
<td>A</td>
</tr>
<tr>
<td>Hypothyroidism Screening: Newborns</td>
<td>Screening</td>
<td>2008</td>
<td>Screen for congenital hypothyroidism in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>Screening</td>
<td>2013</td>
<td>Screen females of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>B</td>
</tr>
</tbody>
</table>
## 10. MEDICAL CARE STANDARDS

### C. Pediatric Preventive Services

#### 1. Well Child Visits

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<tr>
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<tbody>
<tr>
<td>Obesity Screening and Counseling: Children</td>
<td>Screening, Counseling</td>
<td>2017</td>
<td>Screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
<td>B</td>
</tr>
<tr>
<td>Phenylketonuria Screening: Newborns</td>
<td>Screening</td>
<td>2008</td>
<td>Screen for phenylketonuria in newborns.</td>
<td>B</td>
</tr>
<tr>
<td>Perinatal Depression</td>
<td>Interventions, Counseling</td>
<td>2019</td>
<td>Recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.</td>
<td>B</td>
</tr>
<tr>
<td>Preeclampsia Prevention: Aspirin</td>
<td>Interventions</td>
<td>2014</td>
<td>Use low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia.</td>
<td>B</td>
</tr>
<tr>
<td>Preeclampsia Screening</td>
<td>Screening</td>
<td>2017</td>
<td>Pregnant Members are to be screened for preeclampsia with blood pressure measurements throughout pregnancy.</td>
<td>B</td>
</tr>
<tr>
<td>Rh Incompatibility Screening: 1st Pregnancy Visit</td>
<td>Screening</td>
<td>2004</td>
<td>Strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A</td>
</tr>
<tr>
<td>Rh Incompatibility Screening: 24-28 weeks’ gestation</td>
<td>Screening</td>
<td>2004</td>
<td>Recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>B</td>
</tr>
<tr>
<td>Sexually Transmitted Infections Counseling</td>
<td>Counseling</td>
<td>2014</td>
<td>Provide intensive behavioral counseling for all sexually active adolescents.</td>
<td>B</td>
</tr>
<tr>
<td>Skin Cancer Behavioral Counseling</td>
<td>Counseling</td>
<td>2018</td>
<td>Counsel young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce risk for skin cancer.</td>
<td>B</td>
</tr>
<tr>
<td>Tobacco Use Interventions:</td>
<td>Counseling</td>
<td>2013</td>
<td>Provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.</td>
<td>B</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   1. Well Child Visits

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<tbody>
<tr>
<td>Children and Adolescents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use Counseling and Interventions:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Counseling</td>
<td>2015</td>
<td>Ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.</td>
<td>A</td>
</tr>
<tr>
<td>Syphilis Screening: Nonpregnant</td>
<td>Screening</td>
<td>2016</td>
<td>Screen for syphilis infection in all persons who are at increased risk for infection.</td>
<td>A</td>
</tr>
<tr>
<td>Syphilis Screening: Pregnancy</td>
<td>Screening</td>
<td>2009</td>
<td>Screen all pregnant females for syphilis infection.</td>
<td>A</td>
</tr>
<tr>
<td>Visual Screening in Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Cancer Behavioral Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening</td>
<td>2017</td>
<td>Perform vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>2018</td>
<td>Counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.</td>
<td>B</td>
</tr>
</tbody>
</table>

**USPSTF GRADE DEFINITIONS – AFTER JULY 2012**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service for selected patients depending on individual circumstances.</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   1. Well Child Visits

| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I Statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |

USPSTF A and B Recommendations (as of April 2018).
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Administration of Health Assessments

A. Initial Health Assessments must be provided to all Members 18 months or older within one hundred twenty (120) days of initial enrollment and within sixty (60) days following the date of enrollment for Members under age 18 months, unless the PCP determines that the Member’s medical record contains complete and current information consistent with the assessment requirements stated above.

B. Requests for Initial Health Assessments can be made by the Member, their parent(s), or guardian. When a request is made for an initial health assessment, an appointment must be made for the Member to be examined within two (2) weeks of the request. If the child is due for a well child visit based on the well child periodicity schedule, the visit must be scheduled within two (2) weeks.

C. Staying Healthy Assessment (SHA) - Using the age appropriate “Staying Healthy Assessment” tool is required for Medi-Cal Members. Refer to Policy 15F, “Individual Health Education Behavioral Assessment (IHEBA)/ Staying Healthy Assessment (SHA),” for more information on administering IHEBAs.
   1. The Staying Healthy Assessment (SHA) includes screening questions regarding Member’s smoking status and/or exposure to tobacco smoke.
   2. Member are to be annually assessed on their tobacco use status, unless an assessment needs to be re-administered based on the Staying Healthy Assessment’s periodicity schedule.
      a. Providers are to review the questions on tobacco with the Member. This constitutes as individual counseling.
   3. Providers are required to ask Members about their current tobacco use and document this information in their medical record at every visit.
D. Primary Care Providers are required to provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke, in a pediatric setting, is also recommended. Coverage of medically necessary tobacco cessation services, including counseling and pharmacotherapy, is mandatory for children up to the age of 21.

E. With regards to Members identified as using tobacco products. IEHP encourages Providers to implement the following interventional approach:

1. Providers are encouraged to use a validated behavior change model to counsel Members who use tobacco products. Examples include the following which can be found in the Provider Training Material, which can be requested through Providers Services or available online on the Provider Portal:
   a. Use of the “5 A’s” – Ask, Advise, Assess, Assist, and Arrange
   b. Use of the “5 R’s” – Relevance, Risks, Rewards, Roadblocks, and Repetition.

2. Members are able to receive a minimum of four (4) counseling sessions of at least ten (10) minutes per session. Members may choose individual or group counseling conducted in person or by telephone.
   a. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

3. Two (2) quit attempts per year are covered without prior authorization and there are no mandatory breaks between quit attempts.
   a. Current Procedure Terminology and ICD codes for tobacco use are available on the Provider Training Guide, which can be requested through Provider Services or available online on the Provider Portal.

4. Members are to be referred to the California Smoker’s Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline’s web referral, or if available in their area, the Helpline’s e-referral system

5. Providers are strongly encouraged to implement the recommendations from the U.S. Department of Health and Human Services Public Health Services (USPHS) “Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update.” This document is accessible at: [https://bphc.hrsa.gov/buckets/treatingtobacco.pdf](https://bphc.hrsa.gov/buckets/treatingtobacco.pdf)

F. PCPs are required to refer children to a dentist annually, starting at age 3. A referral may be made earlier or more frequently if dental problems are suspected or detected.
G. PCPs are mandated to follow the latest Centers for Disease Control and Prevention (CDC) Guidelines for TB control as part of the health assessment. This includes the use of Mantoux tuberculin skin testing with subsequent reading within forty-eight (48) to seventy-two (72) hours by a trained health Provider. Guidelines are available from the internet through the CDC web page at www.cdc.gov.

H. PCPs are responsible for providing all necessary treatment and/or diagnostic testing identified at the time of the health assessment that are within their scope of practice. For services needed beyond their scope of practice, PCPs are responsible for requesting and/or arranging necessary referrals to appropriate Practitioners either directly (e.g., behavioral health, substance abuse) or through their IPA (e.g., in-plan specialty referrals, specialized diagnostic testing).

I. Diagnosis and treatment of any medical conditions identified through any pediatric preventive services assessment must be initiated within sixty (60) days of the assessment.

J. Notification

1. IEHP notifies Members of the availability of health assessment services upon enrollment through the Post-Enrollment Kit and Benefits Sheet. Ongoing notification takes place through the Member Newsletter and IEHP staff contact, as appropriate.

2. At each non-emergency primary care encounter with a Member under the age of 21 years, PCPs are required to advise the Member, and/or parent(s) or guardian of the Member, of the pediatric preventive services available, and give information on how to access the services.

3. Written notification and an explanation of the results of health assessments must be supplied to the Member, or the parent(s) or guardian of the minor Member. The PCP must also provide discussion or consultation regarding the results of the assessment, if appropriate, or if requested by the Member, or the parent(s) or guardian.

4. In a situation where a Medi-Cal Member has been scheduled for or has begun the health assessment process, and then disenrolls, or becomes ineligible with IEHP prior to the completion of screening and related diagnostic and treatment services, the PCP may continue to provide care through the CHDP 200% program, if the PCP is certified by the County CHDP Program. If the PCP is not an approved CHDP Practitioner, the Member must be referred to the LHD CHDP Program, to receive assistance in accessing a certified CHDP Practitioner. IEHP Member Services maintains current lists of certified CHDP Practitioners in the counties and helps facilitate the referral process as needed.

K. Appointments for Pediatric Preventive Services

1. When a request is made for pediatric preventive services by a Member, the Member’s parent or guardian, or through a referral from the local County CHDP Program, an appointment must be made for the Member to be examined within two (2) weeks of the request.
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   1. Well Child Visits

L. The cumulative health record for each Member must contain:
   1. Screening services provided, and results thereof;
   2. Referral for diagnosis and treatment;
   3. Results of diagnosis and treatment services;
   4. Outreach and follow-up activities to assure that Members have received needed services; and
   5. Notation of acceptance or refusal of services by Member, parent(s), or guardian.

M. Reporting

Appropriate Common Procedure Terminology (CPT) codes must be used when reporting claim and encounter data. See Policy 21A, “Encounter Data Submission Requirements.”

N. Training

1. IEHP does not require CHDP certification; however, all PCPs are required to provide pediatric preventive services according to Bright Futures/AAP standards, and all PCPs must be trained on Bright Futures/AAP guidelines. IPAs must provide documentation that all PCPs have received adequate training on Bright Futures/AAP requirements. PCPs are considered adequately trained if they have attended Local Health Department (LHD) training or have been trained by IEHP or their IPA using an IEHP approved training outline.

O. Revision of Schedule

1. The IEHP Well Child Visit schedule is reviewed annually and revised to reflect any changes in the AAP, ACIP, and CHDP guidelines.
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   1. Well Child Visits

REFERENCES:

   http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

B. American Academy of Pediatrics – Bright Futures. 

C. USPSTF A and B Recommendations (as of April 2018). 
   https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

D. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-014, Supersedes PL 14-006, “Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries.”


F. U.S. Public Health Service’s Advisory Committee on Immunization Practices (ACIP) 

G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-017, Supersedes PL 02-01, “Blood Lead Screening of Young Children.”

H. California Department of Public Health (CDPH) Title 17, Section 37100.

I. DHCS APL 19-010 Supersedes APL 18-007 and 07-008, “Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21”.

INLAND EMPIRE HEALTH PLAN

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IEHP Provider Policy and Procedure Manual 01/19
Medi-Cal

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10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
   2. Immunization Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with State and Federal standards, IEHP requires all IEHP Primary Care Physicians (PCPs) and Practitioners to provide immunization services according to the most recent U.S. Public Health Service’s Advisory Committee on Immunization Practice (ACIP) recommendations, regardless of the Member’s age, sex, or medical condition, including pregnancy (See Attachment, “Recommended and Catch-Up Childhood Immunization Schedules” in Section 10). When the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers are to administer immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

B. Pursuant to State requirements, Medi-Cal Members can access immunization services through Local Health Department (LHD) immunization clinics.

C. IEHP contracts define immunization services as an IPA responsibility.

D. Immunizations are preventive services not subject to prior authorization requirements.

E. All Primary Care Physicians (PCPs) who have Members assigned ages 0-19 must enroll with the Vaccines for Children (VFC) program to ensure a supply of free vaccine for Medi-Cal Members.

PROCEDURES:

A. IEHP provides IPAs and Primary Care Physicians (PCPs) with updated copies of the schedule as they become available from the Centers for Disease Control and Prevention (CDC) or State Department of Health Care Services (DHCS) Immunization Branch. PCPs are mandated to provide immunizations as part of the IEHP Well Child program in conjunction with periodic well child assessments. In addition, other types of visits (acute or follow-up) should be utilized to immunize children that are behind schedule.

B. If a PCP receives information from the Local Health Department (LHD), an immunization registry, other health Provider, or the Member (parent), that adequately documents an immunization(s) has been received by the Member, the PCP is responsible for documenting the received immunization(s) in the medical record and for assessing the need and timing of any additional immunization appropriate for the Member.

C. Access:
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C. Pediatric Preventive Services

2. Immunization Services

1. In order to maximize the provision of immunizations, all Members should access immunization services through their assigned PCP. Medi-Cal Members may also access San Bernardino and Riverside County LHD immunization clinics.

2. Immunizations are preventive services not subject to prior authorization requirements.

3. IEHP requires network Providers to document each Member’s need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:
   a) Illness, care management, or follow-up appointments
   b) Initial Health Assessments (IHAs)
   c) Pharmacy services
   d) Prenatal and postpartum care
   e) Pre-travel visits
   f) Sports, school, or work physicals
   g) Visits to a LHD
   h) Well patient checkups

4. In instances where the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers will provide immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

5. When a Medi-Cal Member accesses an LHD clinic for immunizations, the LHDs are responsible for ensuring non-duplication of immunization services. The LHD clinic utilizes the California Immunization Registry (CAIR), the Member’s California Immunization Record, or contacts the Member’s PCP, to determine the immunization status of the Member. Members needing follow-up care are referred back to their PCP by the LHD.

D. Recording and Tracking Member Immunizations – Practitioners and IPAs must maintain a system to record and track Member immunizations, which includes the following elements:

1. A record of immunizations must be maintained in each Member’s medical record.

2. Practitioners or Providers must review each medical record before a Member’s appointment to determine any needed immunizations, which are then administered as appropriate during the appointment.

3. Members must be asked their immunization history and whether they have recently received any immunizations from out-of-network practitioners. If any recent immunizations are identified, the PCP verifies the immunization by looking up the
10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services

2. Immunization Services

Member in the Immunization Registry, or by confirming the Member’s immunization history through the IEHP Provider website. The information must then be entered into the Member’s medical record.

4. Whenever a vaccine is administered, it must be documented in the Member’s medical record. For each immunization administered, documentation must include the type of immunization, series, lot number, manufacturer, expiration date, injection site and initials of the person administering the immunization.

a. Providers must periodically report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR). Reports must be made after a Member’s IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within fourteen (14) days of administration.

b. Participating Providers can enter and access all relevant immunization data for any child tracked by the system, including children receiving immunizations at different sites. Providers interested in participating and enrolling in the program should call the following number for information: CAIR Inland Empire Region at (951) 358-7143. Further information and web access are also available online at www.cairweb.org.

5. Documentation for tuberculosis skin tests should also include a notation of the reading or that the Member did not return for the reading, if applicable.

6. Practitioners must give Members documentation of their immunizations via the California Immunization Record.

7. Follow-up must be documented for missed appointments as outlined in Policy 9B, “Missed Appointments.”

8. Practitioners or Providers must review medical records at periodic intervals to determine compliance with the ACIP immunization schedule.

9. Immunization updates received from the LHD must be recorded in the Member’s medical record.

E. Reimbursement of LHDs for Immunizations administered to Medi-Cal Members only:

1. LHD clinics must be reimbursed an administration fee, at current Medi-Cal rates, for immunizations services provided, excluding immunizations for which the Members is already up-to-date.

2. Conditions for Reimbursement:

a. The LHD must submit claims to the IPA on CMS 1500 billing forms, using the appropriate CPT and ICD codes.
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C. Pediatric Preventive Services

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b. The LHD must provide immunization records. If a Member refuses the release of medical information, the LHD must submit documentation of such a refusal.

c. Misdirected claims from LHD for immunization services submitted to IEHP will be returned to the LHD for resubmission to the appropriate IPA.

3. Vaccine Reimbursement Process for IEHP Members not enrolled in the Vaccines for Children (VFC) Program is as follows:

a. Physicians must submit a CMS 1500 claim form to IEHP.

b. Physicians must complete the CMS 1500 by including the appropriate CPT codes, quantity dispensed and billed amount.

c. Claims are to be submitted to:

   IEHP Claims Department
   P.O. Box 4349
   Rancho Cucamonga, CA 91729-4349

F. Vaccines for Children – All PCPs with Members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) program. VFC is a federally funded and state-operated program that supplies practitioners with vaccine for administration to children who meet eligibility requirements, including Medi-Cal enrollees. For more information on VFC call (877) 243-8832.

REFERENCES:


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10. MEDICAL CARE STANDARDS

G. Family Planning Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP contracts define professional services associated with family planning as an IPA responsibility. This responsibility includes payment for services accessed by Medi-Cal Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self-refer without prior authorization to a qualified family planning Practitioner within or outside of the IEHP network.

C. A physician, physician assistant, a certified nurse midwife, and nurse practitioner are authorized to dispense medication. Pursuant to the California Business and Professions (B&P) Code, Section 2725.2, if contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier ‘TD.’

IEHP will cover up to a twelve (12) month supply of FDA approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a Provider or Pharmacist or at a location licensed or authorized to dispense drugs or supplies.

DEFINITIONS:

A. Family Planning Services - Services provided to individuals of child-bearing age to temporarily or permanently prevent or delay pregnancy.

B. Qualified Family Planning Practitioner - A Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.

PROCEDURES:

A. Services:

1. The following list of services may be provided to IEHP Medi-Cal Members as part of the family planning benefit:
   a. Health education and counseling necessary to make informed choices and understand contraceptive methods;
10. MEDICAL CARE STANDARDS

G. Family Planning Services

b. Verbal history and physical examination limited to immediate problem;
c. Laboratory tests, if medically indicated as part of decision making process for choice of contraceptive methods;
d. Follow-up care for complications associated with contraceptive methods issued by the family planning Practitioner;
e. Provision of contraceptive pills or patches, vaginal rings, devices, and supplies in an on-site clinic and billed by a qualified family planning Provider or Practitioner. The formulary status and quantity limit are determined based on guidance from the Department of Health Care Services (DHCS) and are listed under the IEHP Formulary.
f. Provision and insertion of birth control implant or Intrauterine Device (IUDs);
g. Tubal ligation;
h. Vasectomies;
i. Pregnancy testing and counseling;
j. Diagnosis and treatment of Sexually Transmitted Infections (STI), if medically indicated (STI diagnosis and treatment provided during a family planning encounter are considered part of family planning services); and
k. Screening, testing and counseling of at risk individuals for HIV (HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services).

2. Therapeutic and elective abortions are not considered a part of family planning services.

3. Infertility studies, reversal of voluntary sterilization, and hysterectomy for sterilization are not included under the Family Planning benefit.

B. Freedom of Choice

1. Members are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services in a timely and confidential manner. Medi-Cal Members are informed upon enrollment that they have a right to access family planning services within and outside IEHP’s network without prior authorization.

2. Members receive Family Planning and freedom of choice information from IEHP in the following ways:
   a. Member Handbook;
   b. Relevant IEHP Health Education programs and materials;
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c. Member Newsletter; and
d. Member Services contacts.

C. Informed Consent

1. Practitioners must furnish Members with sufficient information, in terms that a Member can understand, so that an informed decision can be made. All IEHP and out-of-network family planning services Practitioners must obtain informed consent for all contraceptive methods, including sterilization. A sample informed consent for contraceptive methods other than sterilization is attached (See Attachments, “Contraceptive Informed Choice Form – English” and “Contraceptive Informed Choice Form – Spanish” in Section 10). In the event that the Member is unable to give consent, his/her legal guardian must make appropriate care decisions as needed.

2. Practitioners are required to keep copies of signed informed consent forms in the Member’s medical record as well as submit these with any claims forms.

D. Accessing Family Planning Services

1. Medi-Cal Members select a qualified family planning Practitioner of their choice within the IEHP network, or out-of-network. IEHP Member Services refers Members who request additional information to the State Office of Family Planning at (800) 942-1054 to receive more information on qualified family planning Practitioners.

2. Minors aged 12 and older may access family planning services without parental consent. Please see Policy 9E, “Access to Sensitive Services” for more information.

3. Out-of-network family planning Practitioners are expected to demonstrate a reasonable effort to coordinate services with IEHP network Practitioners, including educating Members to return to their Primary Care Physician (PCP) for continuity and coordination of care.

4. Members should be encouraged to approve release of their medical records from the family planning Provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services. A sample release form for out-of-network family planning services is attached (See Attachments, “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English” and “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish” in Section 10).

5. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality, but allows family planning service Practitioners adequate information to bill the IPA. Practitioners must make such a form available to Members. A sample form in both English and Spanish is
G.  Family Planning Services


E.  Coordination of Care - Listed below are the roles and responsibilities of the PCP, out-of-network family planning Practitioner, IPA and IEHP staff in coordinating care for Medi-Cal Members accessing out-of-network Practitioners for family planning.

1. Out-of-network Practitioners should encourage Members to sign release of information forms so that clinical information can be forwarded to the Member’s PCP (See Attachments, “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English” and “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish” in Section 10). If a release is signed, and the Member needs care as a follow-up to the family planning services or due to a complication of the family planning service, the out-of-network Practitioner must contact the PCP or IPA Case Management (CM).

2. The Member’s assigned PCP is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., PAP smear, type of birth control method) upon receiving medical records from or being informed by the family planning Practitioner or Member.

3. If informed by a family planning Practitioner that follow-up is needed for a Member, IPA CM is responsible for informing the PCP and ensuring that all necessary follow-up or additional services are arranged for through the PCP or specialty Practitioner as indicated.

4. If IEHP CM is informed by a family planning Practitioner, or by the Member directly, that additional health care services are needed, IEHP CM contacts IPA CM to coordinate care.

F.  Out-of-Network Family Planning Services Reimbursement

1. Family planning services, including related STI, and HIV counseling and laboratory testing, provided through Local Health Department (LHD) clinics and out-of-network family planning Practitioners, are reimbursed at the Medi-Cal fee-for-service rate unless otherwise negotiated in subcontracts with IEHP Providers.

2. Conditions for Reimbursement
   a. The family planning Practitioner must submit claims to the Member’s IPA or the IEHP Claims Department on a CMS 1500 form, using the appropriate CPT and ICD codes.
   
   b. The family planning Practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network Practitioner must submit documentation of the refusal.
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G. Family Planning Services

c. IPAs must issue payment for family planning claims within thirty (30) business days of receiving the claim.

d. Family planning billing grievances are resolved in accordance with the Provider Grievance Process. See Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeal Resolution Process.”

REFERENCES:

A. Title 22, California Code of Regulations, § 51200.
B. California Business and Professions Code § 2725.2.
10. MEDICAL CARE STANDARDS

D. Obstetrical Services
   1. Guidelines for Obstetrical Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. All Providers of obstetrical (OB) services to Members are required to follow the most current edition of the American Congress of Obstetricians and Gynecologists’ (ACOG) Guidelines for Perinatal Care, as the minimum standard of care. When applicable, Providers are required to also follow Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF).

B. In addition to medical OB services, OB practitioners provide all Medi-Cal Members with perinatal support services, including an initial comprehensive risk assessment, reassessments, and interventions as determined by risk. Members must have an Individualized Care Plan (ICP) developed that outlines a plan for addressing specific risks. These services are to be offered in the medical, health education, nutrition, and psychosocial areas. Participation in support services is voluntary and Members have the right to refuse any or all of the services offered.

C. All Members may initiate perinatal services without prior authorization with any OB practitioner contracted with their assigned Delegate. This includes basic and low risk nutrition, health education, and psychosocial support services. Referrals for high risk OB, nutrition, health education, and psychosocial services are processed through the Delegate’s regular authorization process.

DEFINITION:

A. Delegate – For the purpose of this policy, this is defined as a medical group, Independent Physician Association (IPA) or any contracted organization delegated to perform Care Management (CM) activities.

PROCEDURES:

Identification of Pregnant Members

A. Providers who are credentialed to provide OB services to Members are encouraged to report specific information regarding pregnant Members to IEHP through the Perinatal and Postpartum components of the Pay-For-Performance (P4P) Program. In addition, IEHP identifies Members who are pregnant through claims data, encounter data, pharmacy, data, laboratory results, data collected through the utilization management (UM) or care management (CM) processes, authorizations, and referrals.
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   1. Guidelines for Obstetrical Services

Accessing Perinatal Services

A. Once the Primary Care Physician (PCP) or any other specialist has established that the Member is pregnant, the Member may initiate prenatal care from an IEHP OB Practitioner approved to provide OB services (or by another Specialist in the same Delegate as the PCP). Members may receive assistance from the PCP, Delegate, or IEHP in scheduling an appointment.

B. The initial prenatal visit must be made within one (1) week of the request. Urgent prenatal visits must be scheduled the same day. Prenatal care should be initiated within the first trimester whenever possible.

C. In accordance with state law, IEHP requires all Delegates to allow women direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.

D. Medi-Cal Members may access basic perinatal support services without prior authorization from the Delegate. Basic services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments by trimester, and low risk interventions conducted in the OB specialist’s office. Referrals for high-risk OB conditions, health education, nutrition, or psychosocial services are processed through the Delegate’s standard authorization process.

Initial Evaluation

A. The initial prenatal evaluation consists of the following:

   1. Physical examination to evaluate the Member’s current condition, including height, weight, blood pressure, breast exam, abdominal exam, and external and internal genitalia evaluation as appropriate;

   2. A written OB record must be initiated, including:
      a. Comprehensive health history with information on current pregnancy, menstrual history, family planning methods used, detailed history of past pregnancies and outcomes, medication sensitivities and allergies, family health and social history to include alcohol, tobacco, depression screening, interpartner violence screening and substance abuse;
      b. Immunization history is to be obtained and reviewed. Assessment and provision for needed immunizations is to be performed.
         1) Members are to receive immunization according to the most recent U.S. Public Health Service’s Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule.
         2) In instances where the Medi-Cal Provider Manual outlines
10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

immunization criteria less restrictive than ACIP criteria, Providers will provide immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

3) Immunizations are preventive services not subject to prior authorization requirements.

4) IEHP requires network Providers to document each Member’s need for ACIP-recommended immunizations as part of all regular prenatal and postpartum health visits.

5) Providers must periodically report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR). Reports must be made after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within fourteen (14) days of administration.

c. Data on current pregnancy to assist physician in estimating date of delivery;

d. Orders for, and/or results of, laboratory procedures; and

e. Diagnostic procedures as indicated.

3. Laboratory tests to include:

a. CBC;
b. Urinalysis and microscopic examination or culture;
c. Urine testing to detect asymptomatic bacteriuria;
d. Blood group and Rh type determination;
e. Rubella antibody titer measurement;
f. Gonorrhea culture, VDRL/RPR and Chlamydia;
g. Antibody screen;
h. Cervical cytology (Pap test) and HPV testing, if indicated;
i. Hepatitis B testing;
j. HIV testing and counseling;
k. TB screen as indicated by risk status;
l. Toxicology screen as indicated by risk status; and

m. Early Screening for gestational diabetics as indicated by risk status.
10. MEDICAL CARE STANDARDS

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   1. Guidelines for Obstetrical Services

B. Assessment of diabetic risk factors necessitating glucose screening, and any other risk factors that may affect treatment (e.g., other medical conditions, significant past medical history, etc.).

C. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (Grade A recommendation). Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, Members should be offered tailored, one-on-one counseling exceeding minimal advice to quit described below.

1. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

2. Providers are required to ask all pregnant Members if they use tobacco or are exposed to tobacco smoke at every doctor visit. Pregnant Members who smoke should obtain assistance with quitting throughout their pregnancies.

3. ACOG recommends clinical interventions and strategies for pregnant women who smoke.

4. Providers are to offer at least one (1) face-to-face tobacco cessation counseling session per quit attempt. Face-to-face tobacco cessation counseling services may be provided by, or under supervision of, a physician legally authorized to furnish such services under state law. Tobacco cessation counseling services are covered for sixty (60) days after delivery, plus any additional days needed to end the respective month.

5. Two (2) quit attempts per year are covered without prior authorization and there are no mandatory breaks between quit attempts.
   a. Current Procedure Terminology (CPT) and ICD codes for tobacco use are available on the Provider Training Guide, which can be requested through Providers Services or available online on the Provider Portal.

6. Providers are to ensure pregnant Members who use tobacco are referred to the California Smoker’s Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline’s web referral, or if available in their area, the Helpline’s e-referral system.

D. The initial prenatal evaluation must also consist of the following unless the Member declines:

1. Assessment of nutritional, educational, and psychosocial risk factors, with the development of an Individual Care Plan (ICP), and interventions as appropriate. IEHP supplies a standard risk assessment form that must be used by all
10. MEDICAL CARE STANDARDS

D. Obstetrical Services
   1. Guidelines for Obstetrical Services

   Practitioners (See Attachments “Initial Perinatal Risk Assessment Form – English,” “Initial Perinatal Risk Assessment Form - Spanish,” “Combined 2nd Trimester Reassessment,” “Combined 3rd Trimester Reassessment” and “Combined Post-Partum Assessment” in Section 10). The assessment process must include the development of an ICP, and interventions as appropriate. The interventions must be designed to ameliorate or remedy the specified risk condition and must be consistent with the requirements of Title 22, CCR, Sections 51348 and 51348.1 (See Attachment, “Comprehensive Perinatal Services - Title 22, Section 51348.1” in Section 10).

   2. Each Member’s ICP must include the following elements:
      a. Documentation of the Member’s risk conditions;
      b. Identification of proposed interventions;
      c. Identification of method(s) of intervention (e.g., referral, counseling by a specified staff person);
      d. Anticipated outcome of intervention; and
      e. Identification of staff person responsible.

   3. Medi-Cal Members should receive care through a multi-disciplinary team approach, with interventions by a variety of types of staff as needed. Examples are included in Policy 10D3, “Obstetrical Services - Multi-Disciplinary Perinatal Services.”

   4. Each Member’s ICP must be reviewed in the second and third trimesters, and in the postpartum period. The ICP should be reviewed more often as the Member’s risk status requires, and updated accordingly.

   5. If a Member refuses any or all risk assessments, a note documenting the attempt and refusal must be noted in the medical record.

E. The OB Practitioner must record the Member’s health history on an approved prenatal medical record form. Refer to the delivering hospital as to which forms are acceptable for use. An example of an approved form is the ACOG Antepartum record (See Attachment, “ACOG Antepartum Record” in Section 10).

F. All Members must receive a prescription for prenatal vitamins as a standard of care.

Antepartum Care

A. Visits for an uncomplicated pregnancy include an exam every four (4) weeks for the first twenty-eight (28) weeks of pregnancy, every two to three (2-3) weeks until thirty-six (36) weeks of gestation, and weekly thereafter. Women with active medical or OB problems should be seen more frequently, at intervals determined by the nature and severity of the problems.
10. MEDICAL CARE STANDARDS

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B. Each antepartum visit must include the following:
   1. Measurement of blood pressure;
   2. Weight;
   3. Measured fundal height;
   4. Fetal heart rate; and
   5. Estimated fetal size and position.

C. The following tests/screens must be offered at the appropriate times during the pregnancy, or as required:
   1. Prenatal genetic screening tests:
      a. Full Integrated Screening – combines first and second trimester blood tests result with Nuchal Translucency (NT) ultrasound results.
      b. Serum Integrated Screening – combines first and second trimester blood tests results.
      c. Quad Market Screening – second trimester specimen drawn at 15-20 weeks of pregnancy.
      See “Genetic Screening” section in this policy for additional genetic screening requirements.
   2. Re-measurement of Hemoglobin or Hematocrit as indicated;
   3. Gestational diabetes screening (24-28 weeks);
   4. Repeat tests for STIs as needed;
   5. Repeat antibody tests for Rh-negative patients (24-28 weeks);
   6. Group B Streptococcus screening (for 3rd trimester screening, universal screening at approximately 35-37 weeks gestation);
   7. Counseling and testing for HIV if not done at initial visit or at increased risk;
   8. Ultrasound (18-20 weeks); and
   9. Cystic Fibrosis screening.

D. Members must receive a re-assessment of Member’s risk status, including nutrition, health education, and psychosocial. The OB Practitioner conducts reassessments for nutrition, health education and psychosocial risks at the second and third trimester of pregnancy using the IEHP mandated reassessment forms (See Attachments, “Initial Perinatal Risk Assessment Form – English,” “Initial Perinatal Risk Assessment Form – Spanish,” “Combined 2nd Trimester Reassessment”, “Combined 3rd Trimester Reassessment” and “Combined Post-Partum Assessment” in Section 10). The OB
10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

Practitioner assesses risk factors and the need to access appropriate specialists to assist in the provision of care. IEHP OB Practitioners are responsible for the provision of counseling for nutrition, health education and psychosocial needs or appropriate referral as required. The ICP should be revised and implemented accordingly.

E. Realizing that the pregnant Member has a variety of needs, IEHP allows perinatal support services to be provided to Medi-Cal program Members by a variety of staff as appropriate. Physicians, non-physician Practitioners, nurses, medical assistants, social workers, dieticians, health educators, or others may provide interventions as suitable.

F. Antenatal screening must be done when indicated to identify possible risks prior to pregnancy. Couples who have increased risks for genetic abnormalities are offered the opportunity to undergo prenatal diagnostic studies after appropriate counseling.

G. OB Practitioners are responsible for all education and specialized diagnostic referrals for their Members, and coordination of all referrals and communication between specialists and PCPs. Delegates are financially responsible for necessary specialty care and/or counseling.

H. As the primary Practitioner of care during pregnancy, the OB Practitioner is responsible for identifying the newborn’s Physician on the antepartum record. In addition, the OB Practitioner, in conjunction with the Delegate and hospital, coordinates referral of the newborn to the IEHP PCP within the mother’s Delegate network for inpatient newborn care and continuing outpatient care. In the event the Member presents without an elected physician, the hospital is to contact the Delegate’s admmitter panel for initial assessment of the newborn.

I. If the newborn was examined in the hospital by a Provider outside of the Member’s Delegate network, for continuity of care, the Delegate will be required to authorize the newborn’s one (1) week assessment with the same Provider, if the Member requests.

J. The OB practitioner is responsible for coordinating the care of the Member back to the PCP after the postpartum evaluation is completed.

K. Dental screening is included as a part of routine prenatal care and is also available through the PCP. The PCP is responsible for screening Members for dental and oral health, and making referral for treatment as appropriate. Referral for dental care does not require prior authorization by the Delegate, and Members may self-refer to Medi-Cal dental practitioners. IEHP Member Services assists both PCPs and Medi-Cal Members in locating dental practitioners by supplying the access number to the Medi-Cal dental referral line.

L. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) or Licensed Midwife (LM). CNMs and LMs must meet IEHP’s credentialing standards, and be contracted with an IEHP Delegate. CNM and LM services are covered when provided by a CNM or LM who belongs to the same Delegate as the Member’s
10.  MEDICAL CARE STANDARDS

D.  Obstetrical Services

1.  Guidelines for Obstetrical Services

PCP. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and the immediate postpartum period. CNMs must have physician back-up with an IEHP obstetrical practitioner who is contracted and credentialed by the Delegate and must have privileges at the Members’ assigned Hospital for consultation, high-risk referral, and delivery services, as needed, as outlined in Policy 10D2, “Obstetrical Services - Obstetric Care by Certified Nurse Midwives.”

M.  Contracted Alternative Birthing Centers (ABCs) with IEHP/Delegates are specialty clinics authorized to provide obstetric and delivery services for Providers and Members who choose to utilize them.

Genetic Screening

A.  ACOG Guidelines and The California Prenatal Screening Program recommendations state that all women who present prior to the 20th week of pregnancy should be offered genetic screening. Members who are assessed as being at risk for genetic disorders must receive counseling and referrals as appropriate.

B.  The California Prenatal Screening Program provides the following services:

<table>
<thead>
<tr>
<th>Quad Marker Screening</th>
<th>One blood specimen drawn at 15 weeks – 20 weeks of pregnancy (current second trimester program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum Integrated Screening</td>
<td>Combines first trimester blood test results (10 weeks – 13 weeks 6 days) with second trimester blood test results</td>
</tr>
<tr>
<td>Full Integrated Screening</td>
<td>Combines first and second trimester blood test results with Nuchal Translucency (NT) ultrasound results performed at 11-14 weeks</td>
</tr>
</tbody>
</table>

Tests are performed only by State approved diagnosis centers (See Attachment, “California Prenatal Screening Program” in Section 10).

C.  Factors which place Members at risk include but are not limited to:

1.  Advanced maternal age (mother 35 years or older at expected time of delivery);
2.  Previous offspring with a chromosomal aberration;
3.  Chromosomal abnormality in either parent;
4.  Family history of a sex-linked condition;
5.  Ancestry indicating risk for Tay-Sachs, sickle cell anemia, or other hemoglobinopathies; and

D.  Antenatal screening must be done whenever indicated to identify possible risks prior to pregnancy. Couples, who have increased risks for genetic abnormalities, are referred to
10. MEDICAL CARE STANDARDS

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   1. Guidelines for Obstetrical Services

   State approved Prenatal Diagnosis Centers for appropriate counseling (See Attachment, “Prenatal Diagnosis Centers – Riverside and San Bernardino” in Section 10).

E. Newborns must also be screened and referred for genetic disorder evaluation as appropriate.

High Risk Obstetrical Care

A. High Risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal Practitioner. Please review the IEHP UM Subcommittee Approved Authorization Guideline on Antepartum Fetal Assessment, which may be found in the secure IEHP Provider Portal.

B. Delegates are responsible for referrals needed by the high-risk Member including but not limited to: education and lifestyle change for gestational diabetics (e.g., California’s Sweet Success program), perinatology, neonatologists or advanced OB and neonatal centers as appropriate.

Intrapartum Care

A. As a part of their prenatal care and counseling, all Members must be informed of the hospital where they are going to deliver. Members are assigned to a hospital based on their PCP’s affiliation. An OB must be able to deliver a Member at her assigned hospital. Members must be reminded that they are to deliver at their assigned hospital, unless they have been directed to deliver at an advanced OB or neonatal center.

B. OB specialists must forward the Members’ medical records to the delivery hospital no later than four (4) weeks prior to the anticipated delivery date. Members must receive instructions on what to do in case of emergency or pre-term labor.

Postpartum Care

A. A postpartum routine review and examination is required between three and eight (3-8) weeks after delivery. The postpartum review must include an interval history and physical examination to evaluate the Member’s current condition that includes: weight, blood pressure, breast exam, abdominal exam, pelvic exam, and depression screening. Laboratory tests should be obtained as necessary as well as an assessment of the Members emotional status.

B. Immunization history is to be reviewed and documented. Provision of needed immunizations according to the most recent ACIP schedule is to be performed.

C. The postpartum visit must also include assessment of nutritional, education, and psychosocial factors, with the development of an ICP and interventions as appropriate.

D. Evaluation includes education on family planning, referral to a pediatric Practitioner for Well Child (CHDP) services, referral to the WIC program as outlined in Policy 10E, “Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)”
10. MEDICAL CARE STANDARDS

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   immunization information, including rubella if appropriate, and evaluation for special
   problems and return-to-work status.

Member’s Rights

A. IEHP informs Members of childbearing age of the availability of perinatal services, and
   how to access services. Members may contact IEHP Member Services Department at
   (800) 440-4347 for information on perinatal services. Members are also informed of the
   availability of services in the Member Handbook, Member Newsletter, Member Services
   contacts, and IEHP Perinatal brochures. Medi-Cal Members’ participation in perinatal
   support services is voluntary and may be refused or discontinued by the Member at any
   time.

Provider Credentialing

A. IEHP requires all Delegates to credential OB specialists, including Physicians, CNMs,
   LMs, Nurse Practitioners, and Physician Assistants, as outlined in Policy 5B,
   “Practitioner Credentialing Requirements for Delegated IPAs” according to IEHP
   standards. Delegates who have been assigned this responsibility must re-credential their
   Practitioners every three (3) years and submit specific updates to IEHP. Non-delegated
   credentialing activities are performed by IEHP.

USPSTF A and B Recommendations Related to Care of the Pregnant Woman

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Year</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Misuse</td>
<td>Screening, Counseling</td>
<td>2013</td>
<td>Screen adults aged 18 or older, including pregnant women, for alcohol misuse and provide appropriate behavioral counseling.</td>
<td>B</td>
</tr>
<tr>
<td>Bacteriuria screening:</td>
<td>Screening</td>
<td>2008</td>
<td>Pregnant females should be screened for asymptomatic bacteriuria with urine culture at 12-16 weeks’ gestation or the first prenatal visit, if later.</td>
<td>A</td>
</tr>
<tr>
<td>pregnant women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Counseling</td>
<td>Counseling</td>
<td>2016</td>
<td>Interventions during pregnancy and after birth should be initiated to promote and support breastfeeding.</td>
<td>B</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Screening</td>
<td>2012</td>
<td>Cervical cancer screening is recommended for women ages 21-65 years with cytology (Pap smear) every 3 years or, for women ages 30-65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>A</td>
</tr>
</tbody>
</table>
### 10. MEDICAL CARE STANDARDS

#### D. Obstetrical Services

1. Guidelines for Obstetrical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
<th>Year</th>
<th>Description</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening: women</td>
<td>Screening</td>
<td>2014</td>
<td>Screen all sexually active females age 24 years or younger and in older women who are at increased risk for infection.</td>
<td>B</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Screening</td>
<td>2016</td>
<td>Screen all adults, including pregnant and postpartum women, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
<td>B</td>
</tr>
<tr>
<td>Folic Acid Supplementation</td>
<td>Intervention</td>
<td>2017</td>
<td>All women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8mg (400 to 800 µg) of folic acid.</td>
<td>A</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.</td>
<td>B</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Screening</td>
<td>2014</td>
<td>Screen for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk of infection.</td>
<td>B</td>
</tr>
<tr>
<td>Gonorrhea Prophylactic Medication: Newborns</td>
<td>Intervention</td>
<td>2019</td>
<td>Use prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.</td>
<td>A</td>
</tr>
<tr>
<td>Hemoglobinopathies screening: newborns</td>
<td>Screening</td>
<td>2007</td>
<td>Screen for sickle cell disease in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>Hepatitis B Screening: Pregnant Women</td>
<td>Screening</td>
<td>2009</td>
<td>Screen for Hepatitis B virus infection in pregnant women at their first prenatal visit.</td>
<td>A</td>
</tr>
<tr>
<td>HIV Screening: Pregnant Women</td>
<td>Screening</td>
<td>2013</td>
<td>Clinicians are to screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.</td>
<td>A</td>
</tr>
<tr>
<td>Hypothyroidism Screening: Newborns</td>
<td>Screening</td>
<td>2008</td>
<td>Screen for congenital hypothyroidism in newborns.</td>
<td>A</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>Screening, Intervention</td>
<td>2013</td>
<td>Screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>B</td>
</tr>
</tbody>
</table>
### 10. MEDICAL CARE STANDARDS

#### D. Obstetrical Services

1. Guidelines for Obstetrical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
<th>Year</th>
<th>Description</th>
<th>Evidence Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal Depression, Counseling</td>
<td>Intervention</td>
<td>2019</td>
<td>Recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.</td>
<td>B</td>
</tr>
<tr>
<td>Phenylketonuria Screening: Newborns</td>
<td>Screening</td>
<td>2008</td>
<td>Screen for phenylketonuria in newborns.</td>
<td>B</td>
</tr>
<tr>
<td>Preeclampsia Prevention: Aspirin</td>
<td>Intervention</td>
<td>2014</td>
<td>Use low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia.</td>
<td>B</td>
</tr>
<tr>
<td>Preeclampsia Screening</td>
<td>Screening</td>
<td>2017</td>
<td>Pregnant Members are to be screened for preeclampsia with blood pressure measurements throughout pregnancy.</td>
<td>B</td>
</tr>
<tr>
<td>Rh Incompatibility Screening: 1st Pregnancy Visit</td>
<td>Screening</td>
<td>2004</td>
<td>Strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A</td>
</tr>
<tr>
<td>Rh Incompatibility Screening: 24-28 weeks’ gestation</td>
<td>Screening</td>
<td>2004</td>
<td>Recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>B</td>
</tr>
<tr>
<td>Counseling</td>
<td>Counseling</td>
<td>2014</td>
<td>Provide intensive behavioral counseling for all sexually active adults who are at increased risk for sexually transmitted infections.</td>
<td>B</td>
</tr>
<tr>
<td>Tobacco Use Counseling and Interventions: Pregnant Women</td>
<td>Counseling, Intervention</td>
<td>2015</td>
<td>Ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.</td>
<td>A</td>
</tr>
<tr>
<td>Syphilis Screening: Pregnant</td>
<td>Screening</td>
<td>2009</td>
<td>Screen all pregnant women for syphilis infection.</td>
<td>A</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

D. Obstetrical Services
   1. Guidelines for Obstetrical Services

<table>
<thead>
<tr>
<th>Women</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis screening in adults</td>
<td>Screening</td>
<td>2016</td>
<td>Screen for latent tuberculosis infection in populations at increased risk.</td>
</tr>
</tbody>
</table>

**USPSTF GRADE DEFINITIONS – AFTER JULY 2012**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service for selected patients depending on individual circumstances.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
<td>Discourage the use of this service.</td>
</tr>
<tr>
<td>I</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
<td>Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

D. Obstetrical Services
   1. Guidelines for Obstetrical Services

REFERENCES:

A. Title 22 California Code of Regulations §§ 51348 and 51348.1.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-014 Supersedes PL 14-006, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries”.


D. UPSPSTF A and B Recommendations (as of April 2018). https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

E. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004 Supersedes PL 96-013 and APL 07-015, Immunization Requirements”.

INLAND EMPIRE HEALTH PLAN

<table>
<thead>
<tr>
<th>Chief Approval: Signature on file</th>
<th>Original Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>September 1, 1996</td>
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</table>

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<thead>
<tr>
<th>Chief Title: Chief Medical Officer</th>
<th>Revision Date:</th>
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<tbody>
<tr>
<td></td>
<td>January 1, 2019</td>
</tr>
</tbody>
</table>
10. MEDICAL CARE STANDARDS

D. Obstetrical Services

2. Obstetric Care by Certified Nurse Midwives

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with Title 22 of the California Code of Regulations, Section 51345, pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM). The CNM must belong to the same IPA as the Member’s Primary Care Physician (PCP).

B. CNMs must contract with IEHP contracted IPAs in order to care for delegated Members. CNMs must contract with IEHP in order to care for IEHP Direct Members.

C. Initiation of prenatal care does not require prior authorization from a PCP or IPA.

PROCEDURES:

A. Once pregnancy has been established by the PCP, Members may either request initiation of prenatal care from an IPA Obstetrician, CNM, contracted Alternative Birthing Centers (ABCs) or other qualified prenatal care practitioner. Nurse midwife services are covered when provided by a CNM contracted with the same IPA as the Member’s PCP. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and the immediate postpartum period. CNMs must be contracted with, and credentialed by IEHP contracted IPAs, and meet IEHPs credentialing standards.

B. CNMs must have physician back up with an IEHP network Obstetrical Practitioner credentialed by the IPA or IEHP for consultation, high-risk referral, and delivery services, as needed.

REFERENCES:

A. Title 22 California Code of Regulations § 51345.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-017, Provision of Certified Nurse Midwife and Alternative Birth Center Facility Services.

INLAND EMPIRE HEALTH PLAN

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</tbody>
</table>
10. MEDICAL CARE STANDARDS

D. Obstetrical Services
   3. Multi-Disciplinary Perinatal Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP Medi-Cal Members, who are pregnant, receive perinatal support services in addition to medical obstetrical (OB) care. Support services are in the areas of nutrition, health education, and psychosocial issues, and are provided by a variety of multi-disciplinary staff, as appropriate.

B. IEHP and IPAs are responsible for assuring the provision and coordination of perinatal support services.

PROCEDURES:

A. In addition to medical OB services, all Members receive perinatal support services, including an initial comprehensive risk assessment, reassessments, and interventions as determined by risk. Members must have an Individualized Care Plan (ICP) developed that outlines a plan for addressing specific risks. These services are to be offered in the medical, health education, nutrition, and psychosocial areas. Participation in support services is voluntary, and Members have the right to refuse any or all of the services offered.

B. If a Member refuses any or all risk assessments, a note documenting the attempt and refusal must be noted in the medical record.

C. Members may access basic perinatal support services from an obstetrical Provider within their IPA’s network, without prior authorization from the IPA. Examples of basic perinatal support services include:
   1. Basic nutritional counseling for women at low nutritional risk due to minor dietary deficiencies;
   2. Basic health education interventions including counseling regarding tobacco use, substance use, exposure to second hand smoke, counseling regarding alcohol use during pregnancy, etc.; and
   3. A basic psychosocial intervention for women with low risk conditions such as counseling women regarding sibling rivalry, and expectations for the pregnancy.

D. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal practitioner’s office. Examples of staff that can provide basic services include:
   1. MD or DO;
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   2. Nurse Practitioner;
   3. Certified Nurse Midwife;
   4. Licensed Midwife;
   5. Registered Nurse;
   6. Licensed Vocational Nurse;
   7. Medical Assistant;
   8. Social Worker;
   9. Health Educator; or

E. Multi-disciplinary staff members in a perinatal Practitioner’s office only provide services within their scope of licensure and appropriate training.

F. Members needing perinatal support services for high-risk conditions identified through the risk assessment tool are referred to the IPA for appropriate intervention utilizing the IPA’s referral authorization process (See Attachments, “Initial Perinatal Risk Assessment Form – English,” “Initial Perinatal Risk Assessment – Spanish,” “Combined 2nd Trimester Reassessment,” “Combined 3rd Trimester Reassessment” and “Combined Post-Partum Reassessment” in Section 10). Examples of high risk conditions are outlined in Policy 10D1, “Obstetrical Services - Guidelines for Obstetric Services.”

G. Perinatal support services for Members with high risk conditions are generally provided outside the perinatal practitioner’s office by licensed professionals including:
   1. Registered Dietitian;
   2. Health Educator with Master’s level degree;
   3. Psychiatrist;
   4. Psychologist; or
   5. MFCC or LCSW.

H. IPA or IEHP Case Management is responsible for assuring the coordination of all multi-disciplinary practitioners providing interventions for pregnant women through transfer of medical records or intervention details, facilitation of necessary referrals and case conferences if necessary.

I. IEHP has the right to monitor compliance by performing random medical record reviews. Failure to offer this service can result in termination from the IEHP network.
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D. Obstetrical Services
   3. Multi-Disciplinary Perinatal Services
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D. Obstetrical Services
   4. PCP Provision of Obstetric Care

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. Primary Care Physicians (PCPs) providing obstetrical (OB) care must be specifically approved by IEHP under criteria set forth below.
B. PCPs can be approved for full OB care, including deliveries and inpatient care, or low risk OB care in an ambulatory setting only, as delineated below.

PROCEDURES:
A. Any Family Practice PCP that provides OB services to Members must be approved by IEHP in either category:
   1. Family Practice 1 (Family Practice including outpatient OB services) – either board certified, three (3) years family practice residency training or rotating internship plus two (2) years residency (PGY-2,3) in Family Practice. Must include signed agreement with delivering OB which states that Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members.
   2. Family Practice 2 (Family Practice including full OB services and delivery) – either board certified, three (3) years family practice residency training. Must include and provide full delivering privileges at an IEHP network hospital, a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e., low-risk, cesarean section, etc.). A written agreement for OB back up Provider must be available. Providers that fulfill these requirements may be referred to and see OB/GYN Members within the same delegated network.
B. After submission of a request, IEHP staff schedules a site visit to determine if all facility criteria are met.
C. IEHP provides written notice to requesting practitioners after the site visit either approving them under, or not approving them with the reasons noted. Refer to Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring” for more information.
D. PCPs denied participation can submit a written appeal to the IEHP Chief Medical Officer within thirty (30) days of the notification of the decision as stated in Attachment, “IEHP Peer Review Level I and Credentialing Appeal” in Section 5.
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D. Obstetrical Services
   4. PCP Provision of Obstetric Care
10. MEDICAL CARE STANDARDS

E. Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP Primary Care Physician (PCP), Obstetrical (OB), and Pediatric Providers must inform Members of the availability of Women, Infants and Children (WIC) services and make appropriate referrals to the local WIC program for their assigned Members who are potentially eligible for WIC services.

DEFINITIONS:

A. For the purpose of this policy, a “Delegate” is defined as a medical group, IPA, or any contracted organization delegated to provide utilization management (UM) services.

PROCEDURES:

A. Informing:

1. The WIC program provides nutrition assessment and education; breastfeeding promotion and support; electronic benefit transfer to meet dietary needs; and referrals to other needed health and social services. WIC works in connection with the participant’s medical Practitioner and encourages ongoing and preventive care.

2. WIC participants must meet the following eligibility criteria:
   a. Be pregnant, breastfeeding, non-breastfeeding (up to six (6) months postpartum), or be an infant child under the age of five (5);
   b. Meets income guidelines (185% Federal Poverty Level);
   c. Lives in the State of California; and
   d. Be identified as having at least one (1) indicator of nutritional need identified by a qualified WIC staff or health professional.

3. Members receive information regarding the availability of WIC Program services through the following methods:
   a. OB, pediatrician, or other PCP;
   b. IEHP Member Services Department;
   c. IEHP Health Education programs and materials; and
   d. Member Newsletter.
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E. Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

4. Providers must identify pregnant, breastfeeding, and postpartum women, as well as infants and children under the age of 5, who would benefit from participating in the WIC program.

B. Referral:

1. Each county WIC program can provide OBs, pediatricians, and other PCPs with WIC informational brochures, educational materials for Members, and PM 247 or CDPH 247A forms for their use when referring Members (See Attachment, “WIC Referral Forms” in Section 10).

2. OBs, pediatricians, and other PCPs assist Members in applying for WIC by providing them with WIC agency phone numbers and the required documentation, including:
   a. height and weight;
   b. results of hemoglobin and hematocrit laboratory tests;
   c. estimated date of delivery for pregnant women;
   d. growth assessment for infants and children; and
   e. any identified nutritional risk factors such as gestational diabetes.

3. Such documentation can be provided to the patient for submission to WIC on the State approved form, the WIC referral form (PM 247 or PM 247A), the physician’s prescription pad, or other reporting forms commonly used by the PCP.

4. The referring Provider must document the WIC referral in the Member’s medical record.

5. If required, the referring Provider must provide additional laboratory test results or other data to the WIC program.

6. For any Member requiring a therapeutic formula, Providers must complete the WIC Pediatric Referral form (CDPH 247A) including Section 2. The Pediatric Referral form must include diagnosis, recommended formula/medical food, duration, and amount.

7. Members must apply for WIC services directly and meet eligibility requirements. IEHP Member Services is available to assist the Member, Practitioner or Delegate in locating the nearest WIC office or with making WIC appointments.

8. WIC appointments - Riverside County (800) 455-4942
   San Bernardino (800) 472-2321
   Out of County (951) 360-8000
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E. Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)
10. MEDICAL CARE STANDARDS

F. Sterilization Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Pursuant to State and Federal requirements, sterilization services (tubal ligation or vasectomy) may be obtained by Medi-Cal Members at any qualified family planning Practitioner in or out of the IPA’s IEHP network.

B. Practitioners providing sterilization services must adhere to informed consent procedures as detailed in Title 22, California Code of Regulations, Section 51305 (1), (2), (3), (4), and outlined below.

C. IEHP contracts define professional services associated with sterilization as an IPA responsibility. This responsibility includes payment of services accessed by the Medi-Cal Member at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient sterilization services.

PROCEDURES:

A. Informed Consent
   1. The Member must be at least 21 years of age, mentally competent to understand the nature of the proposed procedure, and not be institutionalized.
   2. The PM 330 Sterilization Consent Form, which contains federal funding language, must be used, as mandated by the State of California. The form is available in both English and Spanish (See Attachments, “PM 330 Sterilization Consent Form – English” and “PM 330 Sterilization Consent Form – Spanish” in Section 10).
   3. One (1) copy of the State of California approved booklets, in English or Spanish, must be furnished to the Member, along with the consent forms.
   4. The Practitioner must have a discussion with the Member after the Member has read the booklet. This discussion must be noted in the progress notes of the Member’s medical record.
   5. The PM 330 Consent Form must be signed by the Member after the discussion has taken place. If an interpreter is used, he/she must also sign the consent form verifying his/her part in the discussion.
   6. Informed consent may not be obtained while the Member is under the influence of alcohol, or any substance that affects the Member’s state of awareness. Consent may not be obtained while the Member is in labor, within twenty-four (24) hours of delivery, post abortion, or if the Member is seeking to obtain or obtaining an abortion.
10. MEDICAL CARE STANDARDS

F. Sterilization Services

7. Written informed consent must have been given at least thirty (30) days and no more than one hundred eighty (180) days before the procedure is performed. A copy of the consent form must be given to the Member.

8. A hysterectomy requires an additional consent form and is only covered when medically necessary. A hysterectomy is not compensated under the Medi-Cal program if performed or arranged for the sole purpose of rendering the Member sterile.

9. Sterilization may be performed during emergency abdominal surgery or premature delivery if the Member consented to sterilization at least thirty (30) days prior to the intended date of sterilization or the expected date of delivery and at least seventy-two (72) hours have passed between the time that written consent was given and the time of the emergency surgery or premature delivery. The consent must also have been signed seventy-two (72) hours prior to the Member having received any preoperative medication.

10. The PM 330 Sterilization Consent Form must be fully completed at the time of the procedure.

11. Original copies of the informed consent must be filed in the Member’s medical record.

B. Access to Sterilization Services

Medi-Cal Members

1. The Medi-Cal Member selects a qualified family planning Practitioner of their choice within the IEHP network, or out-of-network. Member Services refers Members to the State Office of Family Planning at (800) 942-1054 to receive more information on qualified family planning Practitioners.

2. Out-of-network family planning Practitioners are expected to demonstrate a reasonable effort in coordinating services with IEHP network Practitioners, including educating Members to return to their PCP for continuity and quality of care.

3. Contracted and out-of-network family planning Practitioners must be reimbursed for covered family planning services when the following conditions are met:
   a. The family planning Practitioner must submit claims for sterilization services to the Member’s IPA or IEHP Claims Department on a CMS 1500 form, using the appropriate CPT and ICD codes. PM 330 Sterilization Consent Form must be included with the claim.
   b. The family planning Practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network Practitioner must submit documentation of such a refusal.
   c. IPA must pay claims within thirty (30) days of receipt of claim.
10. MEDICAL CARE STANDARDS

F. Sterilization Services

REFERENCE:

A. Title 22, California Code of Regulations § 51305 (1), (2), (3), (4).
10. MEDICAL CARE STANDARDS

G. Family Planning Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP contracts define professional services associated with family planning as an IPA responsibility. This responsibility includes payment for services accessed by Medi-Cal Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self-refer without prior authorization to a qualified family planning Practitioner within or outside of the IEHP network.

C. A physician, physician assistant, a certified nurse midwife, and nurse practitioner are authorized to dispense medication. Pursuant to the California Business and Professions (B&P) Code, Section 2725.2, if contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier ‘TD.’

DEFINITIONS:

A. Family Planning Services - Services provided to individuals of child-bearing age to temporarily or permanently prevent or delay pregnancy.

B. Qualified Family Planning Practitioner - A Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.

PROCEDURES:

A. Services:

1. The following list of services may be provided to IEHP Medi-Cal Members as part of the family planning benefit:
   a. Health education and counseling necessary to make informed choices and understand contraceptive methods;
   b. Verbal history and physical examination limited to immediate problem;
   c. Laboratory tests, if medically indicated as part of decision making process for choice of contraceptive methods;
10. MEDICAL CARE STANDARDS

G. Family Planning Services

d. Follow-up care for complications associated with contraceptive methods issued by the family planning Practitioner;

e. Provision of contraceptive pills or patches, vaginal rings, devices, and supplies in an on-site clinic and billed by a qualified family planning Provider or Practitioner. The formulary status and quantity limit are determined based on guidance from the Department of Health Care Services (DHCS) and are listed under the IEHP Formulary.

f. Provision and insertion of birth control implant or Intrauterine Device (IUDs);

g. Tubal ligation;

h. Vasectomies;

i. Pregnancy testing and counseling;

j. Diagnosis and treatment of Sexually Transmitted Infections (STI), if medically indicated (STI diagnosis and treatment provided during a family planning encounter are considered part of family planning services); and

k. Screening, testing and counseling of at risk individuals for HIV (HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services).

2. Therapeutic and elective abortions are not considered a part of family planning services.

3. Infertility studies, reversal of voluntary sterilization, and hysterectomy for sterilization are not included under the Family Planning benefit.

B. Freedom of Choice

1. Members are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services in a timely and confidential manner. Medi-Cal Members are informed upon enrollment that they have a right to access family planning services within and outside IEHP’s network without prior authorization.

2. Members receive Family Planning and freedom of choice information from IEHP in the following ways:

   a. Member Handbook;

   b. Relevant IEHP Health Education programs and materials;

   c. Member Newsletter; and

   d. Member Services contacts.
10. MEDICAL CARE STANDARDS

G. Family Planning Services

C. Informed Consent
1. Practitioners must furnish Members with sufficient information, in terms that a Member can understand, so that an informed decision can be made. All IEHP and out-of-network family planning services Practitioners must obtain informed consent for all contraceptive methods, including sterilization. A sample informed consent for contraceptive methods other than sterilization is attached (See Attachments, “Contraceptive Informed Choice Form – English” and “Contraceptive Informed Choice Form – Spanish” in Section 10). In the event that the Member is unable to give consent, his/her legal guardian must make appropriate care decisions as needed.

2. Practitioners are required to keep copies of signed informed consent forms in the Member’s medical record as well as submit these with any claims forms.

D. Accessing Family Planning Services
1. Medi-Cal Members select a qualified family planning Practitioner of their choice within the IEHP network, or out-of-network. IEHP Member Services refers Members who request additional information to the State Office of Family Planning at (800) 942-1054 to receive more information on qualified family planning Practitioners.

2. Minors aged 12 and older may access family planning services without parental consent. Please see Policy 9E, “Access to Sensitive Services” for more information.

3. Out-of-network family planning Practitioners are expected to demonstrate a reasonable effort to coordinate services with IEHP network Practitioners, including educating Members to return to their Primary Care Physician (PCP) for continuity and coordination of care.

4. Members should be encouraged to approve release of their medical records from the family planning Provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services. A sample release form for out-of-network family planning services is attached (See Attachments, “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English” and “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish” in Section 10).

5. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality, but allows family planning service Practitioners adequate information to bill the IPA. Practitioners must make such a form available to Members. A sample form in both English and Spanish is attached (See Attachments, “Authorization for Use and Disclosure of Personal Health Information – English” and “Authorization for Use and Disclosure of Personal Health Information – Spanish” in Section 10).
10. MEDICAL CARE STANDARDS

G. Family Planning Services

E. Coordination of Care - Listed below are the roles and responsibilities of the PCP, out-of-network family planning Practitioner, IPA and IEHP staff in coordinating care for Medi-Cal Members accessing out-of-network Practitioners for family planning.

1. Out-of-network Practitioners should encourage Members to sign release of information forms so that clinical information can be forwarded to the Member’s PCP (See Attachments, “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English” and “Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish” in Section 10). If a release is signed, and the Member needs care as a follow-up to the family planning services or due to a complication of the family planning service, the out-of-network Practitioner must contact the PCP or IPA Case Management (CM).

2. The Member’s assigned PCP is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., PAP smear, type of birth control method) upon receiving medical records from or being informed by the family planning Practitioner or Member.

3. If informed by a family planning Practitioner that follow-up is needed for a Member, IPA CM is responsible for informing the PCP and ensuring that all necessary follow-up or additional services are arranged for through the PCP or specialty Practitioner as indicated.

4. If IEHP CM is informed by a family planning Practitioner, or by the Member directly, that additional health care services are needed, IEHP CM contacts IPA CM to coordinate care.

F. Out-of-Network Family Planning Services Reimbursement

1. Family planning services, including related STI, and HIV counseling and laboratory testing, provided through Local Health Department (LHD) clinics and out-of-network family planning Practitioners, are reimbursed at the Medi-Cal fee-for-service rate unless otherwise negotiated in subcontracts with IEHP Providers.

2. Conditions for Reimbursement
   a. The family planning Practitioner must submit claims to the Member’s IPA or the IEHP Claims Department on a CMS 1500 form, using the appropriate CPT and ICD codes.
   b. The family planning Practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network Practitioner must submit documentation of the refusal.
   c. IPAs must issue payment for family planning claims within thirty (30) business days of receiving the claim.
   d. Family planning billing grievances are resolved in accordance with the
10. MEDICAL CARE STANDARDS

G. Family Planning Services


REFERENCES:

A. Title 22, California Code of Regulations, § 51200.
B. California Business and Professions Code § 2725.2.
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-003 Family Planning Services Policy for Contraceptive Supplies”.

INLAND EMPIRE HEALTH PLAN

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10. MEDICAL CARE STANDARDS

H. Sexually Transmitted Infection Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Physicians (PCPs) and Independent Physician Association (IPAs) are required to follow the latest Sexually Transmitted Infection (STI) treatment guidelines recommended by the U.S. Centers for Disease Control and Prevention (CDC) as published in the Mortality and Morbidity Weekly Report (MMWR).

B. All Medi-Cal Members have the right to seek treatment for STIs from their PCP, the San Bernardino and Riverside County Local Health Department (LHD) clinics, qualified family planning Practitioners, or any other Practitioner who treats STIs within his or her scope of practice. Services may be obtained from a Practitioner within or outside the IEHP network without prior authorization.

C. Members age 12 years and older, may access STI services from Practitioners noted above without parental consent.

D. IEHP contracts define STI services as an IPA’s responsibility. This responsibility includes payment for services accessed by Medi-Cal Members out-of-network.

E. Pursuant to Health and Safety Code Section 120582, licensed physicians, nurse Practitioners, certified nurse-midwives, or physician assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted Chlamydia infection without examination of the Member’s sexual partner or partners.

PROCEDURES:

Access Within Network

A. Medi-Cal Members may elect to receive STI services from any qualified Practitioner, in IEHP’s network without prior authorization.

B. PCPs are required to offer all Members appropriate STI services, including screening, counseling, education, diagnosis and treatment.

C. Practitioners may not require prior authorization for STI services for Medi-Cal Members.

D. Pursuant to California Family Code, Section 6926, Members aged 12 and older may access STI services without parental consent.

Confidentiality and Reporting

A. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside the Practitioner. If they desire,
10. MEDICAL CARE STANDARDS

H. Sexually Transmitted Infection Services

Members may sign a modified release of information form that preserves their medical record confidentiality but gives STI service Practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members.

B. All Practitioners providing STI services are required by law to report individuals with certain communicable diseases to the LHD as outlined in Policy 10K, “Reporting Communicable Diseases to Public Health Authorities.”

C. Medical records for Members presenting for STI evaluation must be maintained to protect the confidentiality of the Member. In-network Practitioners must adhere to IEHP Medical Records policies and procedures. See Policy 7A, “PCP and IPA Medical Record Requirements.”

Access Out-of-Network

A. An out-of-network Practitioner is a Practitioner who is not affiliated with IEHP for the provision of health care services. An out-of-network Practitioner may be a family planning Practitioner, a LHD, or any other Practitioner who provides STI services within their scope of licensure and practice. Members may access STI services through an out-of-network Practitioner without prior authorization.

B. Medi-Cal Members may make their own appointment with the STI services Practitioner of their choice. Members may call IEHP Member Services at 1-800-440-IEHP (4347) for assistance in accessing STI services. IEHP reminds Members to return to their PCPs to maintain continuity of care.

C. IEHP contracts define STI services as an IPA responsibility. This responsibility includes payment of services accessed by the Member out-of-network.

D. Out-of-network Practitioners may call IEHP Member Services at 1-800-440-IEHP (4347) for Medi-Cal eligibility, benefits, benefit exclusions, limitations, and the name of the Member’s IEHP PCP. IEHP reminds the out-of-network Practitioner to refer the Member back to their PCP to maintain continuity of care.

Coordination of Care

A. PCPs are responsible for coordinating care and avoiding duplicate service delivery for those Members who inform them and/or release medical records for out-of-network STI treatment received. In those cases, the PCP is responsible for determining what services were received by the Member, recording or placing in the medical record all pertinent information (assuming consent from the Member) and determining any need for follow-up care, testing or treatment.

B. PCPs are responsible for notifying their IPA Case Management (CM) staff when Members consent to release of information and require case management services due to their STI or medical condition complexity. IPA CM is then responsible for coordinating care including, but not limited to, referral to specialists and transfer of additional medical information.
Reimbursement for Out-of-Network Services

A. The reimbursement for out-of-network Practitioners not associated with a LHD for STI services is limited to one (1) office visit per disease episode for:

1. Diagnosis and treatment of vaginal discharge and urethral discharge;
2. Evaluation and treatment initiation for treatment of Pelvic Inflammatory Disease (PID);
3. Those STIs that are responsive to immediate diagnosis and treatment:
   - syphilis
   - chlamydia
   - chancroid
   - human papilloma virus
   - lymphogranuloma venereum
   - candidiasis
   - gonorrhea
   - herpes simplex
   - Trichomoniasis
   - non-gonococcal urethritis
   - granuloma inguinale
   - bacterial vaginosis

B. For LHDs, reimbursement is available as outlined below:

1. One (1) visit is reimbursable for treatment initiation treatment of vaginal or urethral discharge for symptoms and signs consistent with bacterial vaginosis, trichomoniasis, or candidiasis.
2. Up to six (6) visits are reimbursable for primary and secondary syphilis clinical and serological follow-up and treatment. Documentation should include serologic test results upon which treatment recommendations were made.
3. Initial visit and up to two (2) follow-up visits are reimbursable for chancroid diagnosis and clinical improvement confirmation.
4. A maximum of three (3) visits are reimbursable for lymphogranuloma or granuloma inguinale, based upon the time involved to confirm the diagnosis and the necessary therapy duration necessary.
5. One (1) visit is reimbursable for presumptive diagnosis and treatment of herpes simplex.
6. Gonorrhea, non-gonococcal urethritis and chlamydia can often be presumptively diagnosed and treated in one visit. For individuals with gonorrhea or chlamydia not presumptively treated at the first visit, a second visit for treatment is reimbursed.
7. One (1) visit is reimbursable for diagnosis and therapy initiation for human papilloma virus, with referral to PCP for further follow-up and treatment.
8. Initial visits and two (2) follow-up visits for pelvic inflammatory disease
10. MEDICAL CARE STANDARDS

H. Sexually Transmitted Infection Services

diagnosis, treatment, and urgent follow-up are reimbursable. Members should be referred to their PCP for continued follow-up after the initial three (3) visits have been provided by the LHD.

C. STI services and laboratory testing provided through out-of-network Practitioners must be reimbursed at the Medi-Cal fee-for-service (FFS) rate, unless otherwise negotiated in subcontracts with IEHP contracted IPAs. IEHP contracts define STI services as IPA/Hospital medical services and consider out-of-network STI services as the IPA’s financial responsibility.

D. Guidelines for treatment of various STIs may require that HIV testing and counseling be performed. These tests and counseling procedures are reimbursed at the appropriate Medi-Cal FFS rate. See Policy 10I, “HIV Testing and Counseling” for specific information on HIV testing and counseling procedures.

E. Conditions for Reimbursement

1. The out-of-network Practitioner must submit claims to the Member’s IPA or the IEHP Claims Department on CMS 1500 or UB-04 billing forms using the appropriate CPT and ICD codes that reflect STI diagnosis and treatment.

2. The STI treatment Practitioner must provide proof of service. If a Member refuses the release of medical information, the treating Practitioner must submit refusal documentation.

3. STI treatment Practitioners are not reimbursed for services that fall outside the specific conditions and visits noted above.

4. STI Practitioners are only reimbursed for services provided by a Practitioner within their licensed scope of practice.

5. STI Practitioners are only reimbursed for services provided to IEHP Member.

F. IPA must pay claims within thirty (30) days of claims receipt.

G. Practitioners providing STI services who wish to register a grievance regarding non-payment, underpayment, or any billing related issue may do so by contacting the IEHP Provider Relations Team at (909) 890-2054.

REFERENCES:


B. California Family Code § 6926.

C. Department of Health Care Services (DHCS) Policy Letter (PL) 96-009, Sexually Transmitted Disease Services in Medi-Cal Managed Care.
10. MEDICAL CARE STANDARDS

H. Sexually Transmitted Infection Services

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file  Original Effective Date: September 1, 1996

Chief Title: Chief Medical Officer  Revision Date: January 1, 2019
10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In alignment with recommendations from the United States Preventive Services Task Force (USPSTF), IEHP requires Primary Care Physicians (PCPs) to:
   1. Assess younger adolescents and older adults for Human Immunodeficiency Virus (HIV) infection risk factors;
   2. Screen adolescents and adults ages 15 to 65 years and individuals found to be at risk for HIV infection.

HIV testing and counseling may be offered to Members by their PCP, by a Local Health Department (LHD), or contracted anonymous HIV testing sites.

B. IEHP and Providers are required to follow all State laws governing consent for testing and disclosure of HIV test results, as well as the latest “HIV Counseling, Testing, and Referral Standards and Guidelines” recommended by the U.S. Centers for Disease Control and Prevention (CDC) (Guidelines may be found via the internet at www.cdcnpin.org).

C. IEHP provides IPAs and PCPs with an updated list of LHD operated or contracted HIV testing and counseling sites (See Attachment, “HIV Testing Sites – Riverside and San Bernardino” in Section 10) or this is available at https://ww3.iehp.org/en/providers/forms/um-forms/.

D. IEHP contracts define HIV testing and counseling as an IPA responsibility. For Medi-Cal Members, this responsibility includes payment of services accessed by the Member out-of-network.

E. Medi-Cal Members can access HIV testing and counseling as part of a family planning or STI visit, or at a LHD operated or contracted HIV testing site without prior authorization, and regardless of whether the testing is related to a primary diagnosis.

PROCEDURES:

Access to HIV Counseling and Testing Services Overview

A. In alignment with USPSTF, HIV screening must be offered to Members 15-65 years of age. This screening may be provided by the PCP or through an LHD-operated or contracted HIV testing and counseling site for confidential or anonymous services.

B. Additionally, PCPs are required to assess Members outside of the aforementioned age range for HIV infection risk factors. The assessment can occur in the following situations:
10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

1. As part of a well-child or adult physical exam;
2. At the time of a visit for illness or injury;
3. At the request of a Member, Member’s parent or guardian; or
4. Other appropriate circumstances.

C. The assessment by the PCP should include the following:

1. Obtaining a sexual history in sufficient detail to assess risk;
2. Discussing any history of substance abuse including use of needles;
3. History of significant blood transfusions in past during period of infected blood supply; and
4. If a newborn or young child, the history above for the child’s mother.

D. For those Members identified by the PCP as at risk for HIV infection, one of the following must occur:

1. PCP provides HIV testing and counseling.
2. For Medi-Cal Members, either the PCP refers the Member or the Member can self-refer to a LHD-operated or contracted HIV testing and counseling site for confidential or anonymous services.

E. Members who test positive for HIV at the PCP office must be referred to IPA Case Management staff for evaluation and follow-up as outlined in Policy 12A4, “Case Management Requirements – PCP Role.”

F. Medi-Cal Members can also access HIV testing and counseling services directly and without prior authorization under the following circumstances:

1. As part of a Family Planning visit with any qualified family planning Practitioner, per Policy 10G, “Family Planning Services”;
2. As part of an STI visit at a LHD or other qualified Practitioner, per Policy 10H, “Sexually Transmitted Infection (STI) Services”; or
3. Direct self-referral for anonymous or confidential HIV testing and counseling services at a LHD operated or contracted site.

G. IEHP Member Services is available to assist Members requesting access to HIV testing and counseling services by informing them of their options described above and/or referring them to LHD operated or contracted sites.

HIV Testing and Counseling for Children

A. PCPs and specialists caring for Members who are children must offer to parents or legal guardians HIV counseling, education, and testing, where appropriate, to infants, children and adolescents in the following categories:
10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

1. Infants and children of HIV seropositive mothers;
2. Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:
   a. Children born with a positive drug screen;
   b. Children born to mothers who admit to present or past use of illicit drugs;
   c. Children born with symptoms of drug withdrawal;
   d. Children born to mothers who have arrests for drug-related offenses or prostitution;
   e. Children born to mothers with any male partners at high risk for HIV; and
   f. Any abandoned newborn infants.
3. Sexually abused children and adolescents;
5. Adolescents who engage in high-risk behaviors including unprotected sexual activity, illicit drug use, or who have had STIs; and
6. Other children deemed at high risk by a Practitioner.

B. Medi-Cal Members that are under the age of 21 years who are confirmed HIV positive must be referred to the California Children’s Services (CCS) Program, as outlined in Policy 12B, “California Children’s Services (CCS).”

HIV Testing, Counseling and Follow-up for Prenatal Women

A. IEHP and Delegate network Practitioners who provide women’s health care services must comply with Section 125107 of the California Health and Safety Code, which requires the health care professional primarily responsible for providing prenatal care to a pregnant Member to offer HIV information and counseling to every pregnant Member, including, but not limited to:
   1. Mode of transmission;
   2. Risk reduction and behavior modification including methods to reduce the risk of perinatal transmission; and
   3. Referral to other HIV prevention and psychosocial services.

B. IEHP requires that all prenatal care Practitioners offer HIV testing to every pregnant Member; unless the Member has a positive test result documented in the medical record or has AIDS as diagnosed by a Practitioner.

C. All IEHP prenatal care Practitioners are required to discuss with the Member:
   1. The purpose of the HIV test;
10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

2. Potential risks and benefits of the HIV test, including treatment to reduce transmission to the newborn; and
3. HIV Testing is a voluntary test.

D. Practitioners must document in the Member’s medical record that education, counseling and testing was offered to the pregnant Member.

Out-of-Network Reimbursement for Medi-Cal Members

A. HIV testing and counseling services provided through LHDs, sites subcontracted by LHDs or qualified family planning Practitioners as part of a family planning visit must be reimbursed at the Medi-Cal fee-for-service rate, unless otherwise negotiated between Practitioners.

B. Out-of-network Practitioners must submit claims to the Member’s IPA or the IEHP Claims Department on CMS 1500 billing forms using appropriate CPT and ICD codes.

C. Out-of-network Practitioners must provide proof of service adequate for audit purposes.

D. IPAs must pay claims within thirty (30) days of receipt.

E. All out-of-network Practitioner HIV testing and counseling claims grievances are resolved per the IEHP Provider Grievance Process. See Policy 16C, “Provider (IPA, Hospital & Practitioner) Grievance and Appeals Resolution Process.”

Medical Records

A. All documentation in Member’s charts and release of information regarding HIV tests must conform to all provisions of Health and Safety Code Division 105, Part 4, including Sections 120975, 120980, 120985, and 121010, 199.25, and Insurance Code Section 791.06. See Policy 12B, “California Children’s Services (CCS).” Confidentiality guidelines are set forth below:

1. The Practitioner ordering the test may record the results in the subject’s medical record and disclose the results to other Practitioners for purposes of diagnosis, care or treatment without subject’s written authorization.

2. The Practitioner ordering the test may NOT disclose the results of the test to IEHP or any other health care service plan.

3. All records reflecting HIV testing must be kept in a locked cabinet accessible only by authorized personnel.

Consent of HIV Testing and Disclosure of HIV Test Results

A. All Practitioners ordering HIV tests must either obtain written consent or informed verbal consent from the Member (See Attachments, “Consent for HIV Test – English” and “Consent for HIV Test – Spanish” in Section 10). Informed verbal consent is only sufficient when a treating Practitioner orders the test. This form is available online at https://ww3.iehp.org/en/providers/forms/um-forms/.
10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

B. Except in cases where direct health care Practitioners are disclosing the results of an HIV test for purposes directly related to the Member’s health care, all IEHP network Practitioners must obtain written consent from the Member to disclose results of an HIV test (See Attachments, “Authorization for Use and Disclosure of Personal Health Information - English” and “Authorization for Use and Disclosure of Personal Health Information – Spanish” in Section 10).

Reporting

A. All Practitioners are required to comply with state law and report all known AIDS cases to the Local Health Department, as outlined in Policy 10K, “Reporting Communicable Diseases to Public Health Authorities.”

REFERENCES:

B. California Health and Safety Code §§ 120975, 120980, 120985, and 121010, 199.25.
C. California Insurance Code §791.06.
D. Department of Health Care Services (DHCS) Policy Letter (PL) 97-08, HIV Counseling and Testing Policy.
10. MEDICAL CARE STANDARDS

J. Tuberculosis Services

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

**POLICY:**

A. Primary Care Physicians (PCPs) are required to perform appropriate testing for tuberculosis (TB) based on the most recent recommended guidelines from the Centers for Disease Control and Prevention (CDC). CDC guidelines and tuberculosis treatment updates are available through the CDC web page at: [https://www.cdc.gov/tb/publications/guidelines/pdf/ciw778.pdf](https://www.cdc.gov/tb/publications/guidelines/pdf/ciw778.pdf).

B. PCPs are required to perform the initial diagnostic work-up for TB based on the latest recommended CDC guidelines.

C. PCPs and IPAs are required to refer all confirmed or highly suspected active TB cases to the appropriate Local Health Department (LHD) for treatment and follow-up.

D. IPAs are required to coordinate care between the PCP and LHD for referred Members being treated or evaluated by the LHD.

E. Hospitals are required to report any Member with active TB admitted to an inpatient unit to IEHP by the next normal business day (Monday-Friday).

**PROCEDURES:**

**Guidelines for TB Diagnosis and Treatment**

A. IEHP Providers are required to follow the most current TB diagnostic and treatment guidelines recommended by the CDC, or utilize current California Tuberculosis Controllers Association (CTCA) recommendations.

**Screening for TB Infection**

A. For Members ages 0 to 21 years of age, an assessment for risk factors for developing TB and a TB test must be provided in compliance with the American Academy of Pediatrics (AAP) guidelines and must be provided within one hundred twenty (120) days of enrollment with IEHP.

B. For adult Members 18 years and older, a risk assessment of risk for developing TB is performed as part of the initial health assessment required within one hundred twenty (120) days of enrollment into IEHP. Members under 18 months of age must receive notification of the availability and need for an IHA within sixty (60) days of enrollment. All IEHP Members with an increased risk of TB are offered TB testing unless they have documentation of prior positive test results or TB disease.

C. IEHP requires PCPs to use appropriate TB testing (e.g., interferon-gamma release assay – IGRA, or tuberculin skin testing – TST) in alignment with CDC recommendations based
10. MEDICAL CARE STANDARDS

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on Member age and TB risk. Trained clinic staff must interpret and record the results in the Member’s medical record.

D. Members who test positive and have no evidence of active TB, must be evaluated for TB preventive therapy and treated, if appropriate, per CDC guidelines.

Diagnosis of Active Tuberculosis

A. PCPs are required to initiate the diagnostic work-up for Members suspected of having active TB. Diagnostic work-ups should be performed per the latest CDC guidelines.

B. Potential active TB cases can include test-positive individuals (unless infected with HIV) with the following signs, symptoms, or findings:
   1. Abnormal chest x-ray not typical for pneumonia, particularly upper lobe disease;
   2. Bronchitis or pneumonia unresponsive to antibiotics;
   3. Persistent unexplained constitutional symptoms such as weight loss, fever, night sweats;
   4. Hemoptysis; or
   5. Persistent productive cough not due to asthma, bronchitis or pneumonia.

C. The diagnostic evaluation for potential active TB can include the following:
   1. Chest x-ray, including lordotic views;
   2. Sputum smear for mycobacteria;
   3. Sputum culture for mycobacteria;
   4. Bronchoscopy with biopsy, washings, smear and/or culture;
   5. Chest CT scan; and
   6. Lymph node biopsy if cervical tuberculous lymphadenitis is suspected.

Referrals

A. PCPs and IPAs are required to refer all confirmed (TB3) or highly suspected (TB5) active TB cases to the LHD in the county where the Member resides. The cases must be referred on the same day of suspicion or diagnosis, by phone. A phone call must be made to the appropriate Tuberculosis Program:

   Riverside County  (951) 358-5107
   San Bernardino County  (800) 722-4794

B. PCPs are required to cooperate with any request from the LHDs for medical records, screening, diagnostic work-up, and any other pertinent clinical or administrative information.
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Case Management (CM)

A. IEHP has delegated primary CM responsibilities to IPAs. IEHP provides monitoring and direction to IPA CM for all suspected and active TB cases, as outlined in Policies 12A1, “Case Management Requirements – IEHP Monitoring and Oversight” and 12A2, “Case Management Requirements – IPA Responsibilities.” IEHP assists IPA CM with the notification process to the LHD Tuberculosis Program for all identified Members with suspected or active TB. IPA CM provides the coordination of TB care with the LHD. PCPs must cooperate with all LHD requests for information in a timely manner and consult with the LHD Tuberculosis Program about treatment recommendations and protocols, as needed. IPA CM reports all active or suspected TB cases to IEHP on the monthly CM Log (See Attachment, “Monthly Care Management Report Log” in Section 12).

B. IPA CM, with LHD Tuberculosis Program collaboration, must identify and address barriers to patient compliance with self-administered treatment. To improve adherence, IEHP’s formulary offers fixed-dose combination drug preparations.

C. IPA CM, with assistance from IEHP, coordinates care for Members who have active TB and other co-morbid medical conditions.

Direct Observed Therapy (DOT)

A. IEHP has contracted with the LHDs to provide care and treatment of all active TB cases, including DOT, when needed. The responsibilities of assessing the need for and provision of DOT have been delegated to the LHDs.

B. For Members receiving DOT, the PCPs must share clinical information with the LHD Tuberculosis Program as needed and requested. The PCP must promptly notify the LHD Tuberculosis Program of any significant changes in the Member’s condition or response to medical treatment including adverse drug reactions and dosage changes. IEHP provides all medically necessary medication for Members with TB via the contracted pharmacies.

Hospital Transfers and Discharge

A. Hospital infection control staff, including the attending physician, are required to notify LHDs prior to discharge or transfer of an inpatient case of active TB, per Health and Safety Code, Section 121361 (See Attachment, “Tuberculosis Services – Health and Safety Code 121361” in Section 10).

B. Hospital personnel must use the required form provided by the LHD from the county in which the Member resides.

Reporting

A. IEHP Providers are required to comply with all State laws and regulations pertaining to reporting of confirmed and suspected TB cases to the LHD. IEHP Providers must report known or suspected cases of TB to the LHD TB control programs within one (1) business
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day of identification per Title 17, California Code of Regulations, Section 2500. See Policy 10K, “Reporting Communicable Diseases to Public Health Authorities.”

B. IEHP providers are encouraged to enroll in the California Reportable Disease Information Exchange (CalREDIE). The CalREDIE is a system that the California Department of Public Health has implemented for electronic disease reporting and surveillance.

C. The local health officer may, per State law, require IEHP Practitioners at any time to report any clinical information deemed necessary by the local health officer to protect the Member’s health or the health of the public.

Contact Investigation and Treatment

A. IEHP requires that all PCPs and IPAs cooperate with the LHD in conducting contact and outbreak investigations potentially involving Members. IEHP is available to facilitate and, if necessary, direct the coordination efforts between the LHD, IEHP PCPs and/or Providers.

B. IEHP requires PCPs and Providers to provide appropriate examination and treatment to Members, identified by the LHD as contacts in a timely manner (usually within seven (7) days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner, as defined by the LHD.

C. IEHP coordinates with the IPA to promptly notify the LHD Tuberculosis Program staff when individuals who have come into contact with a previously referred Member; are referred to the LHD Tuberculosis Program staff for care.

Laboratory Services

A. All sputum specimens submitted for culture, including identification and sensitivity, must be directed to a laboratory that meets Title 17, California Code of Regulations, Section 2505 standards. The Public Health laboratories in each county are the preferred option for sputum culture submission, their phone numbers are listed below

<table>
<thead>
<tr>
<th>County</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside County</td>
<td>(951) 358-5070</td>
</tr>
<tr>
<td>San Bernardino County</td>
<td>(909) 383-3000</td>
</tr>
</tbody>
</table>

B. Sputum cultures must be obtained from TB cases at least monthly until culture results are documented negative.

REFERENCES:

B. 17 California Code of Regulations § 2500.
C. 17 California Code of Regulations § 2505.
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K. Reporting Communicable Diseases to Public Health Authorities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP requires that health care Practitioners follow all applicable Federal, State and local statutes, regulations or ordinances related to communicable disease reporting. Practitioners or Providers must ensure that any Member with a reportable communicable disease is reported to public health authorities according to the appropriate statutes, regulations or ordinances. Timely reporting allows public health authorities to determine morbidity, evaluate transmission risk and intervene appropriately to minimize transmission.

B. Failure to report communicable diseases as required by statute, regulation or ordinance can result in negative action taken by the Medical Board of California or IEHP as circumstances warrant.

PROCEDURES:

A. Providers and Practitioners must use the following guidelines to report a CASE or SUSPECTED CASE to the appropriate public health authority:

1. Extremely Urgent Conditions (i.e., Anthrax, Botulism, Cholera, Dengue, Diphtheria, Food Poisoning, Plague, Rabies, Relapsing Fever and Zika Virus Infection) should be reported immediately by telephone, twenty-four (24) hours a day, to the after-hour emergency number listed below (See Attachments, “Reportable Diseases and Conditions – Riverside” and “Reportable Diseases and Conditions – San Bernardino” in Section 10).

2. Other Urgent Conditions should be reported by telephone, mail or electronically submitted within one (1) working day of identifying a case or suspected case (See Attachments, “Reportable Diseases and Conditions – Riverside” and “Reportable Diseases and Conditions – San Bernardino” in Section 10).

3. All Other Non-Urgent Conditions may be reported by phone or mail on confidential morbidity report cards within seven (7) business days of identification (See Attachments, “Reportable Diseases and Conditions – Riverside” and “Reportable Diseases and Conditions – San Bernardino” in Section 10).

4. Animal bites by a species susceptible to rabies are reportable, to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals are identified and may be controlled by this regulation and local ordinances (California Administration Code, Title 17, Sections 2606 et seq., Health and
10. MEDICAL CARE STANDARDS

K. Reporting Communicable Diseases to Public Health Authorities

Safety Code sections 1900-2000). Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing the report. The number in Riverside County is (951) 358-7327 and in San Bernardino County is (800) 472-5609.

B. IEHP Providers are encouraged to participate in the California Reportable Disease Information Exchange (CalREDIE). The CalREDIE is a system that the California Department of Public Health has implemented for electronic disease reporting and surveillance.

C. The report to the public health authorities shall be documented in the medical record and include the report date, the contact at the public health authority and the reporter’s signature.

D. Local Health Departments are responsible for receiving disease reports and coordinating follow-up action between local, regional and state officials. In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to your LHD.

**Riverside County**

Riverside: (951) 358-5107
(951) 358-5102 (confidential fax)
Disease Control Branch
P.O. Box 7600
Riverside, CA 92513-7600

Night & Weekend Emergency: (951) 358-5107

**San Bernardino County**

San Bernardino County: (800) 722-4794
(909) 387-6377 (fax)
Communicable Disease Section
351 N. Mountain View Ave
San Bernardino, CA 92415

Night & Weekend Emergency: (909) 356-3805

**REFERENCES:**

A. Title 17 California Administration Code §§ 2500, 2502-2505, 2508, 2606 et seq.
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L. Vision Examination Level Standards

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. This policy defines vision examination standards for Medi-Cal Members.
B. IEHP’s commitment to providing quality care to Members requires that certain tests be performed during comprehensive and intermediate ophthalmological exams.

PROCEDURES:

A. **Comprehensive Exam**- A comprehensive ophthalmological examination provides a complete history and physical evaluation of the ocular system. The examination may be performed with or without dilation. A comprehensive exam must document each of the following:
   1. Case History to include: personal medical history, including review of systems (ROS); personal ocular history; family medical history; family ocular history.
   2. Qualitative Assessment of Vision: entering visual acuity, either with or without existing correction.
   3. Binocular Function testing to include at least two (2) of the following: stereo test; phorias-horizontal and vertical; vergences; prism reflex test; cover testing; near point of convergence (NPC); accommodation (NRA/PRA).
   4. Health status of the complete visual system including: tonometry; gross visual fields; biomicroscopy; pupillary reflexes; extraocular muscle assessment; ophthalmoscopy; mydriasis, when indicated and necessary.
   5. Initiation of any other necessary diagnostics or treatment procedure/programs.

B. **Intermediate Exam**- An intermediate ophthalmological examination for a new or existing Member must document each of the following:
   1. Case History- specifically the reason for the visit and pertinent medical history; personal medical history, including review of systems (ROS); personal ocular history; family medical history; family ocular history.
   2. Qualitative Assessment of Vision- entering visual acuity; either with or without existing correction.
   3. Health status of the complete visual system including- tonometry; gross visual fields; biomicroscopy; pupillary reflexes; extraocular muscle assessment; ophthalmoscopy; mydriasis, when indicated and necessary.
   4. Other diagnostic procedures as indicated and necessary.
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L. Vision Examination Level Standards

C. **Determination of Refractive State** - The determination of refractive state for a new or existing Member must document each of the following:

1. Objective refraction results
2. Subjective refraction results
3. Best corrected visual acuity (BCVA)

D. IEHP recognizes the importance of allowing Members to have prompt diagnosis and treatment of acute eye conditions. Under the Therapeutic Pharmaceutical Agent (TPA) Certification Program, IEHP credentialed and TPA certified Providers may provide specific services to Members without a referral from the Member’s PCP. In addition to performing TPA services an Optometrist with TPG or TLG certification is allowed to diagnose and treat primary open angle glaucoma in patients over the age of 18 years old. IEHP credentialed Ophthalmology Providers should continue to work through their contracted IPA to provide these services.

E. To ensure Member continuity of care, all Providers participating in the TPA Program are responsible for notifying the Member’s PCP that medical services have been provided. For more information on the TPA Program, please refer to Policy 12L, “Vision Services.”
M. Mandatory Elder or Dependent Adult Abuse Reporting

**APPLIES TO:**

A. This policy applies to Mandated Reporters who treat or have contact with IEHP Medi-Cal Members.

**DEFINITIONS:**

A. **Abuse** – Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering of an Elder or Dependent Adult. Abuse is also the deprivation to an Elder or Dependent Adult by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

1. **Abandonment** – the desertion or willful forsaking of an Elder or a Dependent Adult by anyone having care of custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

2. **Abduction** – the removal from this state and/or the restraint from returning to this state, of any Elder or Dependent Adult who does not have the capacity to consent to such removal and/or restraint from returning. This also applies to the removal or restraint of any conservatee without the consent of the conservator or the court.

3. **Financial Abuse** – the taking or assistance in taking real or personal property of an Elder or Dependent Adult by undue influence, or for a wrongful use or intent to defraud the Elder or Dependent Adult.

4. **Isolation** – acts intentionally committed to prevent an Elder or Dependent Adult from receiving mail, telephone calls, and callers/visitors (when that is contrary to the wishes of the Elder or Dependent Adult). These activities will not constitute isolation if performed pursuant to a physician and surgeon’s instructions, who is caring for the Elder or Dependent Adult at the time, or if performed in response to a reasonably perceived threat of danger to property or physical safety.

5. **Neglect** – the negligent failure of any person having the care or custody of an Elder or a Dependent Adult to exercise a reasonable degree of care. This includes, but is not limited to, the failure to assist in personal hygiene; provide food, clothing, or shelter; provide medical care for physical and mental health needs; failure to protect from health and safety hazards; and failure to prevent malnutrition or dehydration. Neglect includes self-neglect, which is the Elder or Dependent Adult’s inability to satisfy the aforementioned needs for himself or herself.

6. **Physical Abuse** – this includes but is not limited to, assault, battery, unreasonable physical constraint, prolonged/continual deprivation of food or water, sexual assault or battery, rape, incest, sodomy, oral copulation, sexual penetration, lewd
M. Mandatory Elder or Dependent Adult Abuse Reporting

or lascivious acts; or the use of physical or chemical restraint or psychotropic medication for punishment, for a period beyond that which was ordered by a physician and surgeon providing care, or for any purpose not authorized by the physician and surgeon.

B. Dependent Adult – any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

C. Elder – any person residing in this state, 65 years or older.

D. Mandated Reporter – an individual who is required by law to report identified or suspected Elder/Dependent Adult abuse. Such individuals include any person who has assumed full or intermittent responsibility for care or custody of an Elder or Dependent Adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for Elder or Dependent Adults, or any Elder or Dependent Adult care custodian, health practitioner, clergy Member, or employee of a county adult protective services agency or a local law enforcement agency.

E. Ombudsman – the State Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the Department of Aging.

F. Serious Bodily Injury – an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

POLICY:

A. Any Mandated Reporter who, in his or her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be Abuse, is required by law to directly inform appropriate county agencies by telephone immediately or as soon as practically possible. An additional written report shall also be submitted to the appropriate agency(ies) within two (2) working days.¹

B. Mandated Reporters include, but are not limited to: PCPs, specialists, nurses, and IEHP professional staff (i.e. practitioners, care managers, and UM personnel), who treat and/or provide assistance in the delivery of health care services to IEHP Members.

C. Exceptions: Physicians and surgeons, registered nurses, and psychotherapists (as defined in Section 1010 of the Evidence Code) are NOT required to report incidents of Elder/Dependent Adult Abuse when all of the following exist:²

¹ Welfare & Institutions Code § 15630.
² Welfare & Institutions Code § 15630.
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M. Mandatory Elder or Dependent Adult Abuse Reporting

1. The Mandated Reporter has been informed by an Elder/Dependent Adult that he or she has experienced Abuse; and
2. The Mandated Reporter is not aware of any independent evidence that corroborates the statement that the Abuse has occurred; and
3. The Elder/Dependent Adult had been diagnosed with a mental illness or dementia; and
4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist reasonably believes that the Abuse did not occur.

PROCEDURES:

Identification of Suspected Abuse

A. Health Care Providers and caregivers must be alert for signs of possible Elder/Dependent Adult Abuse including, but not limited to, the following signs and symptoms:
   1. Evidence of malnutrition, starvation, dehydration;
   2. Chronic Neglect;
   3. Sexual assault;
   4. Evidence of financial misappropriation or theft from an Elder/Dependent Adult;
   5. Conflicting or inconsistent accounts of incidents and injuries;
   6. Depression, not responding to appropriate therapy, or characterized by suicidal thoughts;
   7. Blunt force trauma that is not consistent with a fall;
   8. Infection due to lack of medical treatment;
   9. A series of accidents, bruises, or fractures over time;
   10. Unexplained illness or injury;
   11. On office visit, the presence of physical findings of trauma inconsistent with a Member’s stated history, or inconsistent with the caregiver’s history. Examples include a stated mechanism of injury not consistent with an Elder/Dependent Adult’s functional capabilities; and/or
   12. On office visit, the presence of behavioral or emotional clues pointing toward possible Abuse. These may include excessive hostility between a Member and his/her caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member.

B. In addition, Mandated Reporters have a variety of further information sources for the identification of Elder/Dependent Adult Abuse cases, including the following (when
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access to such information is available to the Mandated Reporter, and not otherwise prohibited by state or federal law):

1. Request by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;
4. Office visits with Primary Care Physicians (PCPs), and other health care practitioners that reveal unusual physical or emotional findings;
5. Abuse cases identified during the UM or CM process;
6. Requests for assistance received by Member Services from victims of Abuse; and/or
7. Calls to the twenty-four (24) Hour Nurse Advice Line from potential victims of Abuse.

C. Any obligation to investigate the particulars of any case rests with Adult Protective Services. This allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

Reporting of Suspected Abuse

A. Suspected or Alleged Physical Abuse in a Long Term Care Facility

1. Please note: this section relates to reporting suspected physical abuse which occurred in a long-term care facility but not a state mental health hospital or a state development center.

2. If the suspected physical abuse results in serious bodily injury:
   a. A telephone report shall be made to the local law enforcement agency, within two (2) hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding licensing agency, and the local law enforcement agency within two (2) hours of the Mandated Reporter identifying/suspecting the Physical Abuse.

3. If the suspected Physical Abuse does not result in Serious Bodily Injury:
   a. A telephone report shall be made to the local law enforcement agency within twenty-four (24) hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding
M. Mandatory Elder or Dependent Adult Abuse Reporting

licensing agency, and the local law enforcement agency within twenty-four (24) hours of the Mandated Reporter identifying/suspecting the Physical Abuse.

4. If the suspected Physical Abuse is allegedly caused by a resident of the long term care facility who is diagnosed with dementia, and there is no Serious Bodily Injury, the Mandated Reporter shall report to the local Ombudsman or law enforcement agency by telephone, immediately or as soon as practicably possible, and by written report, within twenty-four (24) hours.

B. Suspected or Alleged Abuse (Other Than Physical Abuse) in a Long Term Care Facility

1. **Please note:** this section relates to reporting suspected Abuse (other than Physical Abuse) which occurred in a long-term care facility but not a state mental health hospital or a state development center.

2. If the suspected or alleged Abuse is other than Physical Abuse, a telephone report and a written report shall be made to the local Ombudsman or the local law enforcement agency immediately or as soon as practicably possible. The written report shall be submitted within two (2) working days.

C. Suspected or Alleged Abuse in a State Mental Hospital or a State Development Center

1. If the suspected or alleged Abuse resulted in any of the following incidents, a report shall be made immediately, no later than two (2) hours, by the Mandated Reporter identifying/suspecting Abuse to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, and the local law enforcement agency:
   a. A death.
   b. A sexual assault, as defined in WIC § 15610.63.
   c. An assault with a deadly weapon\(^3\) by a nonresident of the state mental hospital or state development center.
   d. An assault with force likely to produce great bodily injury.\(^4\)
   e. An injury to the genitals when the cause of the injury is undetermined.
   f. A broken bone when the cause of the break is undetermined.

2. All other reports of suspected or alleged Abuse shall also be made within two (2) hours of the Mandated Reporter identifying/suspecting Abuse, to designated investigators of the State Department of State Hospitals or the State Department

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\(^3\) Penal Code § 245.

\(^4\) Penal Code § 245.
10. MEDICAL CARE STANDARDS

M. Mandatory Elder or Dependent Adult Abuse Reporting

of Developmental Services, or to the local law enforcement agency.

3. Reports can be made by telephone or through a confidential Internet reporting tool; if reported by telephone, a written report shall be sent, or an Internet report, within two (2) working days.

D. Abuse Outside of a Long Term Care Facility, State Mental Hospital, or a State Development Center

1. If the Abuse has occurred in any place other than a long-term care facility, a state mental hospital, or state development center, the report shall be made to the adult protective services agency or the local law enforcement agency.

2. Reports can be made by telephone or through a confidential Internet reporting tool; if reported by telephone, a written report shall be sent, or an Internet report, within two (2) working days.

E. Suspected Abuse when a patient transfers to a receiving hospital

1. If the Admitting Physician or other persons affiliated with a hospital receives a patient, transferred from another health care facility or community health facility, who exhibits a physical injury or condition that appears to be due to the result of abuse or neglect, they must submit a telephonic and written report within thirty-six (36) hours to both the police and the local county health department. (See Penal Code § 11161.8)

F. Information to include in Abuse Reports

1. The report shall include the following, if known:
   a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
   b. Name, address, age and present location of the Elder/Dependent Adult.
   c. Any information that led the reporting party to suspect that Abuse has occurred.
   e. The date and time of incident.
   f. Names and addresses of family members or any other person responsible for the Elder/Dependent Adult’s care.
   g. Any other information requested by the adult protective agency.

Riverside
Dependent Adult and Elder Abuse: Adult Services Division
(800) 491-7123 (24 hours)

San Bernardino
Dependent Adult and Elder Abuse: Department of Aging and Adult Services
(877) 565-2020 (24 hours)
10. MEDICAL CARE STANDARDS

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Other Related Responsibilities
A. IPAs are responsible for educating their contracted PCPs and specialists of the procedures for reporting Abuse cases.
B. IPAs are responsible for case managing Abuse cases and verifying that reporting has occurred.
C. IPAs are responsible for documenting Abuse cases on the monthly Case Management Log (See Attachment, “Monthly Care Management Log” in Section 12).

Penalties for Noncompliance
A. Failure to report, or impeding or inhibiting a report of Abuse is a misdemeanor, punishable by not more than six (6) months in the county jail, by a fine of not more than one thousand dollars ($1,000), or both.
B. Any Mandated Reporter who willfully fails to report, or impedes or inhibits a report of Abuse, if that Abuse results in death or great bodily injury, shall be punished by not more than one (1) year in a county jail, by a fine of not more than five thousand dollars ($5,000) or both.
C. If a Mandated Reporter intentionally conceals his/her failure to report an incident known by the Mandated Reporter to be Abuse, the failure to report is a continuing offense until discovered by the applicable law enforcement agency.

REFERENCES:
A. California Welfare and Institutions Code § 15630.
B. California Welfare and Institutions Code § 15610 et seq.
C. California Evidence Code § 1010.
D. California Penal Code § 245.
E. California Penal Code § 11161 et seq.

INLAND EMPIRE HEALTH PLAN
Chief Approval: Signature on file
Original Effective Date: April 1, 2012
Chief Title: Chief Medical Officer
Revision Date: January 1, 2018
10. MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

APPLIES TO:

A. This policy applies to all Mandated Reporters who treat/ or have contact with IEHP Medi-Cal Members.

POLICY:

A. Primary Care Physicians (PCPs) are responsible for the overall health care of assigned Members including the identification and reporting of suspected child abuse or neglect cases.

B. PCPs are Mandated Reporters according to Penal Code Section 11165.7 and as such they are responsible for directly informing Child Protective Services within their respective county, of identified or suspected abuse or neglect cases and filing reports with appropriate county agencies.

C. Other Mandated Reporters, who are also responsible to directly report identified or suspected child abuse or neglect include IEHP professional staff and:

1. Medical, Dental and Hospital Personnel
2. Mental Health Professionals and Counselors
3. Social Service Personnel

D. IEHP adopts the definition of child abuse/neglect from the California Child Abuse and Neglect Reporting Act: physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury. For the full definition of “child abuse or neglect,” see California Penal Code Section 11165.6.

E. Mandated Reporters, will report identified or suspected abuse or neglect such as:

1. A minor who is physically injured by other than accidental means.
2. A minor who is subjected to willful cruelty or unjustifiable punishment.
3. A minor who is abused or exploited sexually.
4. A minor who is neglected by a parent or caretaker who fails to provide adequate food, clothing, shelter, medical care or supervision.

PROCEDURES:

Identification of Suspected Abuse or Neglect Cases

A. At the health plan level, Providers, practitioners, care managers, and UM personnel are in a position to identify and report incidents of potential child abuse or neglect. Any
obligation to investigate the particulars of any case rests with Child Protective Services. This allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

B. Health care givers must be alert for signs of possible child abuse or neglect including, but not limited to, the following signs and symptoms:

1. Evidence of malnutrition, starvation, dehydration, failure to thrive;
2. Chronic neglect;
3. Sexual assault;
4. Exposure to controlled substances, street drugs, or alcohol;
5. Conflicting or inconsistent accounts of incidents and injuries;
6. Depression not responding to appropriate therapy or characterized by suicidal thoughts;
7. Shaken baby syndrome;
8. Blunt force trauma;
9. Infection due to lack of medical treatment;
10. A series of accidents, bruises, or fractures over time;
11. Unexplained illness or injury;
12. Poor or worsening school or work performance not otherwise explained;
13. On office visit, the presence of physical findings of trauma inconsistent with a Member’s stated history, or inconsistent with the parent’s, caregiver’s, or guardian’s history. Examples include a stated mechanism of injury not consistent with a child’s developmental age (e.g., a child who could not have rolled off a bed); and
14. On office visit, the presence of behavioral or emotional clues pointing toward possible abuse or neglect. These may include excessive hostility between a Member and his/her parent or caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; or sexually inappropriate, explicit, or familiar behavior on the part of the Member during the office visit.

C. In addition, Mandated Reporters have a variety of further information sources for the identification of child abuse or neglect cases including the following:

1. Request by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
10. MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;
4. Office visits with Pediatricians, Primary Care Physicians (PCPs), and other health care practitioners that reveal unusual physical or emotional findings;
5. Abuse cases identified during the UM or CM process;
6. Requests for assistance received by Member Services from victims of abuse; and
7. Calls to the twenty-four (24) Hour Nurse Advice Line from victims of abuse.

Reporting Suspected Abuse or Neglect Cases

A. Mandated Reporters are responsible for telephoning reports of suspected child abuse or neglect and filing additional report(s) with appropriate agencies.

1. The telephone report shall include the following:
   a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
   b. Name, address, age and present location of minor.
   c. Any information that led the reporting party to suspect that abuse has occurred.
   d. Nature and extent of the minor’s injury and condition, if known.
   e. The date and time of incident.
   f. Names and addresses of parents or legal guardians.
   g. Any other information requested by the child protective agency.

Riverside
Child Abuse:
Department of Public Social Services
Child Services Division
(800) 442-4918 (24 hours)

San Bernardino
Child Abuse:
Department of Public Social Services
Children and Family Services
(800) 827-8724 (24 hours)

Other Related Responsibilities

A. IPAs are responsible for educating their contracted PCPs of the procedures for reporting abuse or neglect cases.
B. IPAs are responsible for case managing abuse or neglect cases and verifying that reporting has occurred.
C. IPAs are responsible for documenting abuse or neglect cases on the monthly Case
10.  MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

Management Log (See Attachment, “Monthly Case Management Log” in Section 12).

REFERENCES:

A. California Penal Code §11165.6.
B. California Penal Code §11165.7.
10. MEDICAL CARE STANDARDS

O. Mandatory Domestic Violence Reporting

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

**POLICY:**

A. Primary Care Physicians (PCPs) are responsible for the overall health care of assigned Members including the identification and reporting of domestic violence cases.

B. PCPs and Health Care Practitioners who provide medical services are Mandated Reporters according to Penal Code Section 11160 (a) and as such they are responsible for directly informing the local law enforcement agency, within their respective county, of identified domestic violence cases.

C. Mandated Reporters are health practitioners who are:
   1. Acting in their professional capacities or within the scope of their employment; and
   2. Provide medical services for a physical condition to a patient whom they know or reasonably suspect to have been abused. (Penal Code § 11160, subsection (a))

D. Mandated Reporters, will immediately make a report when they identify:
   1. Any person suffering from or whose death is caused by any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.
   2. Any person suffering from or whose death is caused by any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct, including, but not limited to, the following:
      a. Torture;
      b. Assault or battery (unwelcome physical contact); and
      c. Sexual battery, rape including spousal rape.

E. For the complete definition of “assaultive or abuse conduct”, see CA Penal Code Section 11160 (d). Behavioral Health (BH) professionals must comply with their own licensing board requirements in regards to reporting domestic violence, which may be different from PCPs and other medical health care practitioners.
10. MEDICAL CARE STANDARDS

O. Mandatory Domestic Violence Reporting

PROCEDURES:

Identification of domestic violence cases
A. At the health plan level, Providers, practitioners, care managers, and UM personnel are in a position to identify and report incidents of domestic violence. Any obligation to investigate the particulars of any case rests with law enforcement.

1. On office visit, the presence of behavioral or emotional clues pointing toward possible domestic violence. These may include excessive hostility between a Member and his/her partner or spouse; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; and/or physical injuries that are consistent with assault and battery.

B. In addition, Mandated Reporters within IEHP have a variety of further information sources for the identification of domestic violence cases including the following:

1. Domestic violence cases identified during the UM or CM process;
2. Requests for assistance received by Member Services from victims of domestic violence;
3. Calls to the twenty-four (24) Hour Nurse Advice Line from victims of domestic violence.

Reporting Domestic Violence Cases
A. Mandated Reporters are responsible for telephoning reports of domestic violence with the appropriate law enforcement agency and filing an additional written report.

1. The telephone report shall be made immediately or as soon as practically possible to the local law enforcement agency. The telephone report shall include the following:
   a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
   b. Name and present location of the injured person.
   c. The character and extent of the person’s injuries.
   d. The identity of the person who allegedly inflicted the injury.

2. The written report will be faxed to the appropriate law enforcement agency within two (2) business days. The report consists of the Suspicious Injury Report (Form CalEMA-920).

   Riverside                          San Bernardino
   Riverside Sheriff’s Dept.          San Bernardino Sheriff’s Dept.
   951 955-2526 or Call 911          909 884-0156 or Call 911
10. MEDICAL CARE STANDARDS

O. Mandatory Domestic Violence Reporting

Other Related Responsibilities

A. IPAs are responsible for educating their contracted PCPs of the procedures for reporting domestic violence cases.

B. IPAs are responsible for case managing domestic violence cases and verifying that reporting has occurred.

C. IPAs are responsible for documenting domestic violence cases on the monthly Case Management Log (See Attachment, “Monthly Care Management Log” in Section 12).

REFERENCES:

A. California Penal Code §11160 et seq.

B. California Business & Professions Code § 680.
10. MEDICAL CARE STANDARDS

P. Total Fracture Care

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP has implemented a total fracture care policy that allows the Member to be seen by a participating Orthopedist for global fracture care without a prior authorization. This ensures Members in need of fracture care by an Orthopedist, as determined by an ER or Urgent Care Physician or Primary Care Physician (PCP), will receive timely access to care.

B. The participating Orthopedist shall treat the Member and subsequently request authorization from the IPA to ensure claims are processed accordingly. The IPA shall authorize the treatment and payment for global fracture care, including payment for all supplies related to this care.

C. IEHP or its Delegate shall reimburse the participating Orthopedist for global fracture care rendered under the terms of this policy.

PURPOSE:

A. To ensure that Members in need of fracture care by an Orthopedist, as determined by an ER or Urgent Care Physician or PCP, receive timely access to care.

PROCEDURES:

A. When an ER or Urgent Care Physician encounters an IEHP Member with an acute fracture, the ER or Urgent Care Physician shall determine whether the fracture is best treated by an Orthopedist or the Member’s PCP.

1. If the ER or Urgent Care Physician determines it is an orthopedic level injury, the ER or Urgent Care Physician shall choose from the following options:

   a. If immediate care is deemed necessary, refer directly to the Trauma/Ortho Panel doctor on call at the facility; or

2. Refer directly to an Orthopedist participating in this program at the time of the visit or within twenty-four (24) hours. This would best be achieved by calling the respective Orthopedist office and making an appointment, or by giving the patient a prescription or referral form with the Orthopedist’s contact information.

3. If the ER or Urgent Care Physician determines that the patient may be best treated by their PCP, the ER or Urgent Care Physician shall refer the patient to their PCP immediately, with recommendation to refer the Member to an Orthopedist participating in this program within twenty-four to forty-eight (24-48) hours.
B. Participating Orthopedists shall schedule IEHP Members referred for acute fracture care within two to three (2-3) business days of receiving the referral. The participating Orthopedist will not require an authorization from the Member’s IPA prior to scheduling the appointment.

C. The participating Orthopedist shall treat the patient and subsequently request authorization from the IPA to ensure claims are processed accordingly.

D. The participating Orthopedist shall communicate the diagnosis and care plan to the PCP.

E. On an annual basis, the Provider Services Department shall review the list of participating Orthopedists and verify their continued participation. For their information, Delegates and hospitals and Urgent Care facilities will be provided an updated list of participating Orthopedists, which will also be available online at www.iehp.org.
10. Medical Care Standards

Q. Maternal Mental Health Services

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

**POLICY:**

A. All Providers who provide prenatal or postpartum care for a patient are required to offer to screen or appropriately screen a mother for maternal mental health conditions, both during pregnancy and postpartum, as per Postpartum Support International (PSI). This includes all Members who are pregnant, thinking of getting pregnant, or who had a baby/delivery in the past year. Additionally, this will include any women who have lost a pregnancy. For the most up to date information on PSI-recommended screening tools and practices, refer to the following website at: [https://www.postpartum.net/professionals/screening/](https://www.postpartum.net/professionals/screening/).

B. The Behavioral Health (BH) Maternal Mental Health Program takes a proactive approach in addressing disparities when dealing with maternal mental health by providing outreach calls to Members identified as potentially in need.

C. IEHP collaborates with external stakeholders and community partners to provide case management and/or care coordination to ensure these Members receive the high-quality care and services they need.

**PURPOSE:**

A. To promote early identification and coordination of behavioral health services for Members with maternal mental health conditions.

**DEFINITION:**

A. Maternal mental health – Mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

**PROCEDURES:**

**Identification of Members**

A. All IEHP Members are eligible for this program. Members can self-refer by calling Member Services at (800) 440-4347. Any Provider can refer a Member online by submitting a web form request or by phone by calling Provider Services at (909) 890-2054.

B. IEHP Team Members may refer Members to BH if they identify a Member with potential need for maternal mental health services. Members with potential need for maternal mental health services may be identified through health education programs and data analytics.

**Program Enrollment**
10. Medical Care Standards

Q. Maternal Mental Health Services

A. When a referral for maternal mental health services is received, the IEHP Maternal Mental Health Team reviews the Member’s information on the medical management system and calls the Member.

B. The Member decides if they would like to engage services or not. If the Member is interested in services, they are provided care coordination and initial psychoeducation, which may include but is not limited to the following topics: importance of immunizations, post-partum appointments, and education on how to enroll newborn(s) for Medi-Cal. Additionally, Members are screened and assessed for behavioral health services which may include individual therapy, psychiatry, and/or support groups.

C. IEHP also links Member to community resources and external IEHP services, such as classes at the Community Resource Center and nurse case management. IEHP provides continued outreach and support as needed.

REFERENCE:

A. CH HCS Code 123640.
10. MEDICAL CARE STANDARDS

Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tbody>
<tr>
<td>ACOG Antepartum Record</td>
<td>10D1</td>
</tr>
<tr>
<td>Authorization for Use and Disclosure of Personal Health Information - English</td>
<td>10G, 10I</td>
</tr>
<tr>
<td>Authorization for Use and Disclosure of Personal Health Information - Spanish</td>
<td>10G, 10I</td>
</tr>
<tr>
<td>Auth or Refusal to Release Medical Record - Out of Network Family Planning – English</td>
<td>7C, 10G</td>
</tr>
<tr>
<td>Auth or Refusal to Release Medical Record - Out of Network Family Planning – Spanish</td>
<td>7C, 10G</td>
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<tr>
<td>California Prenatal Screening Program</td>
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<tr>
<td>Combined 2nd Trimester Reassessment</td>
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<tr>
<td>Combined 3rd Trimester Reassessment</td>
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<tr>
<td>Combined Post Partum Assessment</td>
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<tr>
<td>Comprehensive Prenatal Services Title 22 Section 51348</td>
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<tr>
<td>Consent for HIV Test – English</td>
<td>7C, 10I</td>
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<tr>
<td>Consent for HIV Test – Spanish</td>
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<tr>
<td>Contraceptive Informed Choice Form – English</td>
<td>7C, 10G</td>
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<tr>
<td>Contraceptive Informed Choice Form – Spanish</td>
<td>7C, 10G</td>
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<tr>
<td>Developmental Screening Tests at Discounted Rate</td>
<td>10C1</td>
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<tr>
<td>HIV Testing Sites – Riverside and San Bernardino</td>
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<tr>
<td>Initial Perinatal Risk Assessment Form – English</td>
<td>10D1</td>
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<td>Initial Perinatal Risk Assessment Form – Spanish</td>
<td>10D1</td>
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<tr>
<td>Maternity Coverage – Health and Safety Code 1367.62</td>
<td>10C1</td>
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<tr>
<td>Periodicity Schedule – Dental</td>
<td>10C1</td>
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<tr>
<td>PM 330 Sterilization Consent Form – English</td>
<td>7C, 10F</td>
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<tr>
<td>PM 330 Sterilization Consent Form – Spanish</td>
<td>7C, 10F</td>
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<tr>
<td>Pregnancy Notification Form/Outcome Report</td>
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<tr>
<td>Prenatal Diagnosis Centers – Riverside and San Bernardino</td>
<td>10D1, 12N</td>
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<tr>
<td>Recommendations and Catch-Up Childhood</td>
<td>10C2</td>
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</table>
10. MEDICAL CARE STANDARDS

Attachments

Immunizations Schedule
Recommendations for Preventive Pediatric Health Care 10C1
Reportable Diseases and Conditions – Riverside 10K
Reportable Diseases and Conditions – San Bernardino 10K
Tuberculosis Services – Health and Safety Code 12361 10J
WIC Referral Forms 10E
**Attachment 10 - ACOG Antepartum Record**

**Patient Addressograph**

---

**DATE**

**NAME**

**LAST**

**FIRST**

**MIDDLE**

**ID #**

**HOSPITAL OF DELIVERY**

**NEWBORN'S PHYSICIAN**

**REFERRED BY**

**PRIMARY PROVIDER/GROUP**

---

**FINAL EDD**

**ADDRESS**

---

**BIRTH DATE**

**AGE**

**RACE**

**MARTIAL STATUS**

**S, M, W, O, S**

**OCCUPATION**

**EDUCATION**

**LAST GRADE COMPLETED**

**ADDRESS**

**ZIP**

**PHONE**

---

**LANGUAGE**

**ETHNICITY**

**INSURANCE CARRIER/MEDICARE ID #**

**HUSBAND/DOMESTIC PARTNER**

**PHONE**

**POLICY #**

**FATHER OF BABY**

**PHONE**

**EMERGENCY CONTACT**

**PHONE**

**TOTAL PREG**

**FULL TERM**

**PREMATURE**

**AB, INDUCED**

**AB, SPONTANEOUS**

**EOTOPHS**

**MULTIPLE BIRTHS**

**LIVING**

---

**LMP**

**DEFINITE**

**APPROXIMATE (MONTH KNOWN)**

**MENSES MONTHLY**

**YES**

**NO**

**FREQUENCY**

**DAYS**

**MENARCHE**

**AGE ONSET**

**UNKNOWN**

**NORMAL AMOUNT/ DURATION**

**PRIOR MENSES DATE**

**ON TOP AT CONCEPTION**

**YES**

**NO**

**HCG +**

**FINAL**

---

**PAST PREGNANCIES (LAST SIX)**

<table>
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<tr>
<th>DATE</th>
<th>GA</th>
<th>LENGTH OF LABOR</th>
<th>BIRTH WEIGHT</th>
<th>SEX</th>
<th>TYPE DELIVERY</th>
<th>ANESTHESIA</th>
<th>PLACE OF DELIVERY</th>
<th>PRETERM UNBORN VESICO</th>
<th>COMMENTS/ COMPLICATIONS</th>
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**MEDICAL HISTORY**

1. **DIABETES**

2. **HYPERTENSION**

3. **HEART DISEASE**

4. **AUTOIMMUNE DISORDER**

5. **KIDNEY DISEASE/ULATE**

6. **NEUROLOGIC/PSYSC**

7. **PSYCHIATRIC**

8. **DEPRESSION/POSTPARTUM DEPRESSION**

9. **HEMPTHRUS/PERDINE**

10. **VARICOSE VEINS/EPILEPSY**

11. **THYROID DYSFUNCTION**

12. **TRAUMA/VIOLENCE**

13. **HISTORY OF BLOOD TRANSFUS**

14. **TOBACCO**

15. **ALCOHOL**

16. **ILLICIT/RECREATIONAL DRUGS**

17. **D (RH) SENSITIZED**

18. **PULMONARY (E, ASTHMA)**

19. **SEASONAL ALLERGIES**

20. **DRUG/ALLERGIES/ REACTIONS**

21. **BREAST**

22. **CERVICAL SUTURING**

23. **OPERATIONAL HOSPITALIZATIONS (YEAR & REASON)**

24. **ANESTHETIC COMPLICATIONS**

25. **HISTORY OF ABNORMAL P.P**

26. **UTERINE ANOMALIES**

27. **INTERFETILITY**

28. **ART TREATMENT**

29. **RELEVANT FAMILY HISTORY**

30. **OTHER**

---

**COMMENTS**

---
### Symptoms Since LMP

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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### Genetic Screening/Teratology Counseling

Includes patient, baby’s father, or anyone in either family with:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Patient’s age 35 years or older as of estimated date of delivery</td>
<td>13. Huntington’s chorea</td>
</tr>
<tr>
<td>2. Thalassemia (Italian, Greek, Mediterranean, or Asian background): MoV less than 80</td>
<td>14. Mental retardation/autism</td>
</tr>
<tr>
<td>3. Neural tube defect (meningomyelocele, spina bifida, or anencephaly)</td>
<td>If yes, was person tested for Fragile X?</td>
</tr>
<tr>
<td>4. Congenital heart defect</td>
<td>15. Other inherited genetic or chromosomal disorder</td>
</tr>
<tr>
<td>5. Down syndrome</td>
<td>16. Maternal metabolic disorder (e.g., type 1 diabetes, PKU)</td>
</tr>
<tr>
<td>6. Tay-Sachs (Ashkenazi Jewish, or in French-Canadian)</td>
<td>17. Patient or baby’s father had a child with birth defects not listed above</td>
</tr>
<tr>
<td>7. Canavan disease (Ashkenazi Jewish)</td>
<td>18. Medications including supplements, vitamins, herbs, or OTC drugs used for preconceptional drug use since last menstrual period</td>
</tr>
<tr>
<td>8. Familial dysautonomia (Ashkenazi Jewish)</td>
<td>19. If yes, agent(s) and strength/dosage</td>
</tr>
<tr>
<td>9. Sickle cell disease or trait (African)</td>
<td>20. Any other</td>
</tr>
<tr>
<td>10. Hemophilia or other blood disorders</td>
<td></td>
</tr>
<tr>
<td>11. Muscular dystrophy</td>
<td></td>
</tr>
<tr>
<td>12. Cystic fibrosis</td>
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### Comments/Counseling

- [ ]

### Infection History

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Live with someone with TB or exposed to TB</td>
<td>4. Herpes B/C</td>
</tr>
<tr>
<td>2. Patient or partner has history of genital herpes</td>
<td>5. History of STD, Gonorrhea, Chlamydia, HIV, HSV, Syphilis (circle all that apply)</td>
</tr>
<tr>
<td>3. Past or present illness since last menstrual period</td>
<td>6. Other (see comments)</td>
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### Comments

- [ ]

### Initial Physical Examination

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<tr>
<th>Date</th>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
<th>BP</th>
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</thead>
<tbody>
<tr>
<td>1. Head</td>
<td>Normal</td>
<td>Abnormal</td>
<td>12. Vagina</td>
<td>Normal</td>
</tr>
<tr>
<td>2. Fundi</td>
<td>Normal</td>
<td>Abnormal</td>
<td>13. Cervix</td>
<td>Normal</td>
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<tr>
<td>3. Teeth</td>
<td>Normal</td>
<td>Abnormal</td>
<td>14. Thyroid</td>
<td>Normal</td>
</tr>
<tr>
<td>5. Breast</td>
<td>Normal</td>
<td>Abnormal</td>
<td>17. Adnexa</td>
<td>Normal</td>
</tr>
<tr>
<td>7. Heart</td>
<td>Normal</td>
<td>Abnormal</td>
<td>19. Diastole</td>
<td>Normal</td>
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<tr>
<td>10. Skin</td>
<td>Normal</td>
<td>Abnormal</td>
<td>22. Gynecoid pelvic type</td>
<td>Yes</td>
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### Comments

(Number and explain abnormalities)

EXAM BY

INTERVIEWER’S SIGNATURE
### ACOG Antepartum Record (Form C)

**NAME:**

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
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**Drug Allergy:**

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<tr>
<th>Latex Allergy</th>
<th>Yes</th>
<th>No</th>
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**Is Blood Transfusion Acceptable?**

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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**Antepartum Anesthesia Consult Planned?**

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<tr>
<th>Yes</th>
<th>No</th>
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### Problems/Plans

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### Medication List (Include Dosage)

<table>
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<tr>
<th>Start Date</th>
<th>Stop Date</th>
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### EDD Confirmation

<table>
<thead>
<tr>
<th>LMP</th>
<th>EDD</th>
<th>Initial EDD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 18–20 Week EDD Update

<table>
<thead>
<tr>
<th>Quickening</th>
<th>+22 Wks</th>
<th>+20 Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prepregnancy Weight:**

<table>
<thead>
<tr>
<th>Week's Gest</th>
<th>Birth Weight</th>
<th>Presentation</th>
<th>PTA Movement</th>
<th>Blood Pressure</th>
<th>Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).*
## LABORATORY AND EDUCATION

<table>
<thead>
<tr>
<th>INITIAL LABS</th>
<th>DATE</th>
<th>RESULT</th>
<th>REVIEWED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Type</td>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>D (Rh) Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibody Screen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/HBV/CMV</td>
<td></td>
<td><strong><strong>%</strong></strong></td>
<td>g/dL</td>
</tr>
<tr>
<td>Pap Test</td>
<td></td>
<td>Normal/Abnormal/___</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VDRL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine Culture/Screen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Counseling/Testing*</td>
<td></td>
<td>POS, NEG, DECLINED</td>
<td></td>
</tr>
</tbody>
</table>

### OPTIONAL LABS

<table>
<thead>
<tr>
<th>HEMOGLOBIN ELECTROPHORESIS</th>
<th>DATE</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AA, AS, SC, SC, AF, 1/2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>PPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>Tay-Sachs</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>Familial Dysautonomia</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>Hemooglobin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic Screening Tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See Form B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 8-20 WEEK LABS

<table>
<thead>
<tr>
<th>8-20 WEEK LABS (WHEN INDICATED ELECTED)</th>
<th>DATE</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Trimester Anomaly Risk Assessment</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>Multiple Markers</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>2nd Trimester Gout Phenotyping</td>
<td></td>
<td>POS, NEG, DECLINED</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karyotype</td>
<td></td>
<td>46,XX, OR 46,XYY/OTHER</td>
</tr>
<tr>
<td>Amniotic Fluid (MFD)</td>
<td></td>
<td>Normal__ Abnormal__</td>
</tr>
<tr>
<td>Anti-D Immune Globulin (Rhe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Check state requirements before recording results.

<table>
<thead>
<tr>
<th>PROVIDER SIGNATURE (AS REQUIRED)</th>
<th></th>
</tr>
</thead>
</table>

(continued)
## Laboratory and Education (continued)

<table>
<thead>
<tr>
<th>24-28-Week Labs (When Indicated)</th>
<th>Date</th>
<th>Result</th>
<th>Comments/Additional Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT/HGB/HMoM</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Diabetes Screen</td>
<td>/ /</td>
<td>1 Hour</td>
<td></td>
</tr>
<tr>
<td>Gtt (If Screen Abnormal)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>T (if Screen Normal)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>LD (if Abnormal)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Anti-D Immune Globulin (Rho)</td>
<td>/ /</td>
<td>Signature</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32-36-Week Labs</th>
<th>Date</th>
<th>Result</th>
<th>Comments/Additional Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT/Hgb</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Ultrasound (When Indicated)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>HIV (When Indicated)*</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>VDRL (When Indicated)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea (When Indicated)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Chlamydia (When Indicated)</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Group B Strep</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

*Check state requirements before recording results.

## Comments

- 
- 
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- 
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- 
- 
- 
- 
- 
- 
- 

Provider Signature (as required)
# ACOG Antepartum Record

## Plans/Education

### First Trimester

- [ ] HIV and other routine prenatal tests
- [ ] Risk factors identified by prenatal history
- [ ] Anticipated course of prenatal care
- [ ] Nutrition and weight gain counseling; special diet
- [ ] Toxoplasmosis precautions (cat's raw meat)
- [ ] Sexual activity
- [ ] Exercise
- [ ] Influenza vaccine
- [ ] Smoking counseling
- [ ] Environmental work hazards
- [ ] Travel
- [ ] Tobacco (ask, advise, assess, assist, and arrange)
- [ ] Alcohol
- [ ] Illicit/creational drugs
- [ ] Use of any medications (including supplements, vitamins, herbs, or OTC drugs)
- [ ] Indications for ultrasound
- [ ] Domestic violence
- [ ] Seatbelt use
- [ ] Childbirth classes/hospital facilities

### Second Trimester

- [ ] Signs and symptoms of preterm labor
- [ ] Abnormal lab values
- [ ] Influenza vaccine
- [ ] Selecting a newborn care provider
- [ ] Smoking counseling
- [ ] Domestic violence
- [ ] Postpartum family planning/sterilization

## Comments

---

(Continued)
## PLAN/EDUCATION (continued)

(COUNSELED ____)—BY TRIMESTER, INITIALS AND DATE WHEN DISCUSSED.

### THIRD TRIMESTER

<table>
<thead>
<tr>
<th>ANESTHESIA/MANAGEMENT PLANS</th>
<th>COMPLETED</th>
<th>NEED FOR FURTHER DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FETAL MOVEMENT MONITORING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LABOR SIGNS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VBAC COUNSELING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIGNS AND SYMPTOMS OF PREGNANCY-INDUCED HYPERTENSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POSTTERM COUNSELING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIRCUMCISION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BREAST OR BOTTLE FEEDING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POSTPARTUM DEPRESSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFLUENZA VACCINE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMOKING COUNSELING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOMESTIC VIOLENCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEWBORN EDUCATION (NEWBORN SCREENING, JAUNDICE, SIDS, CAR SEAT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAMILY MEDICAL LEAVE OR DISABILITY FORMS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REQUESTS

______________________________
______________________________
______________________________
______________________________

### TUBAL STERILIZATION CONSENT SIGNED

DATE          INITIALS

### HISTORY AND PHYSICAL HAVE BEEN SENT TO HOSPITAL IF APPLICABLE

DATE          INITIALS

### COMMENTS

______________________________
______________________________
______________________________
______________________________

ACOG ANTEPARTUM RECORD (FORM E, continued)
Plans/Education Notes
**Supplemental Visits**

<table>
<thead>
<tr>
<th>PREPREGNANCY WEIGHT</th>
<th>WEEKS 35</th>
<th>BP/SGT</th>
<th>BSM</th>
<th>PRN</th>
<th>FCM</th>
<th>DMD</th>
<th>ACOG Doc/Ref</th>
<th>OB Comm</th>
<th>BP/SGT</th>
<th>WBC</th>
<th>RBC</th>
<th>Hgb</th>
<th>RBC Diff</th>
<th>ESR</th>
<th>PEs</th>
<th>NURSING REPORT</th>
<th>PROVIDER NOTES</th>
</tr>
</thead>
</table>

*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).*

**Progress Notes**

---

**Sample**

---

**Provider Signature (as required):** ____________________________
RECOMMENDED SAMPLE
Authorization or Refusal to Release Medical Records
for Out-of-Network Family Planning Services

Name: ________________________________
   Last First Middle Initial

Address: ________________________________
   Street

   City State Zip

Date of Birth: ________________
Client Record No.: ________________________________

CONSENT TO RELEASE MEDICAL RECORDS:
I hereby REQUEST AND AUTHORIZE ________________________________ to release
   (name of clinic)

From/sent to (circle one or both)
   ________________________________ any information and
   (name of managed care plan)

Records related to the diagnosis and treatment of me by you from ________________ to ________________
   (date) (date)

Date: ________________
Patient’s Signature: ________________________________

Date: ________________
Patient’s Signature: ________________________________

REFUSAL TO RELEASE MEDICAL RECORDS:
A. I hereby request that you DO NOT:
  ☐ Release to my plan any information and/or medical records related to diagnosis and treatment
   provided to me by your clinic.

B. I hereby request that you DO NOT
  ☐ Submit a bill to my plan for processing and payment.

Date: ________________
Patient’s Signature: ________________________________

Date: ________________
Patient’s Signature: ________________________________

Instructions:
1. Use to obtain consent to release and/or send medical records – Consent Section  Keep original in record.
2. Use to document absolute confidentiality – Item A & B  Keep original in record.
3. Use to document medical record refusal – Item A only  Keep original in record.
EJEMPLAR RECOMENDADO
Autorización o Rechazo a Liberar el Historial Médico
para Servicios de Planificación Familiar Fuera del Plan

Nombre: __________________________ Apellido __________________________ Primer Nombre __________________________ Inicial del Segundo Nombre __________________________

Domicilio: __________________________
Calle __________________________
Ciudad __________________________ Estado __________________________ Zona Postal __________________________

Fecha de Nacimiento: __________________________ Número de Registro de Cliente: __________________________

CONSENTIMIENTO PARA LIBERAR EL HISTORIAL MÉDICO:
Por este medio SOLICITO Y AUTORIZO a __________________________ a liberar __________________________ de/enviar a (circule una o ambas) __________________________ toda información e __________________________ (nombre del plan de administración de servicios médicos)
Historial relacionado con mi diagnóstico y tratamiento de usted de __________________________ a __________________________ (fecha) (fecha)
Fecha: __________________________ Firma del Paciente: __________________________
Fecha: __________________________ Firma del Paciente: __________________________

RECHAZO A LIBERAR EL HISTORIAL MÉDICO:
A. Por este medio solicito que ustedes NO:
Liberen a mi plan cualquier información y/o historial médico relacionado con diagnóstico y tratamiento que me proporcionó su clínica.
B. Por este medio solicito que ustedes NO
Presenten una factura a mi plan para procesamiento y pago.
Fecha: __________________________ Firma del Paciente: __________________________
Fecha: __________________________ Firma del Paciente: __________________________

Instrucciones:
1. Uso para obtener consentimiento para liberar y/o enviar historial clínico –Sección de Consentimiento Conservar el original en el registro.
2. Uso para documentar confidencialidad absoluta – Ítem A y B Conservar el original en el registro.
3. Uso para documentar rechazo de historial médico – Sólo Ítem A Conservar el original en el registro.
HIPAA, federal regulations and California law require that this Authorization be completed to authorize Inland Empire Health Plan (IEHP) to use and disclose Protected Health Information (PHI).

I __________________________ authorize IEHP to use or disclose this Member’s PHI, as described below:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member ID # or Social Security #</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address (for delivery)</td>
<td>Apt/Unit #</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Phone #</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate the type of PHI records you are requesting:*  
- Care Management
- Referrals/Authorizations
- Prescription
- Claims/Billing
- Grievance & Appeals Case Management
- Enrollment/Eligibility

Enter the date range of PHI records needed:          /         / to          /         /

Please indicate the purpose(s) for disclosing or using PHI:
- Legal
- Personal Use
- Insurance
- Other (Please specify) __________

* IEHP does not maintain individual medical and/or clinical records. These records are in the custody of the professionals/entities that provided the healthcare service(s) i.e., Primary Care Physicians, Specialists, Hospitals, etc.

I read this Authorization and agree to the use and disclosure of PHI as specified.  

<table>
<thead>
<tr>
<th>Name of Member (printed)</th>
<th>Signature of Member</th>
<th>Date</th>
</tr>
</thead>
</table>

If signing for the Member, then describe your authority to act on the Member’s behalf (e.g., parent of minor child or legal guardian):

Note: Appropriate documentation of the legal representative’s authority must be on file with IEHP.

<table>
<thead>
<tr>
<th>Name of Member’s Legal Representative (printed)</th>
<th>Signature of Member’s Legal Representative</th>
<th>Date</th>
</tr>
</thead>
</table>

The Authorization is effective immediately and will remain in effect until       /       /       .  
(ending date)
**Authorization of Release**

Use & Disclosure of Protected Health Information

**REQUIREDDelivery Options:** (please check one)
- Pick-up at IEHP (Monday – Friday, 8am - 11am and 1pm - 4pm)*
- FedEx Delivery
- Secure E-mail Portal*

**RECORD DELIVERY**

* In order to protect your privacy, IEHP delivers PHI using a secure e-mail portal. Upon request, IEHP can deliver your PHI using an unencrypted and unsecure e-mail portal. However, IEHP is not responsible or liable for breaches that may occur if PHI is sent using an unencrypted and unsecure e-mail. If you are requesting IEHP deliver your PHI using an unencrypted and unsecure e-mail portal, and accept the security risks with using this method, please initial here ______.

**If delivering to a person/entity other than yourself or your legal representative, please state the name and contact information of the person/entity authorized to receive your PHI records:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Member</th>
</tr>
</thead>
</table>

**NOTICE OF RIGHTS AND OTHER INFORMATION**

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits. I am aware that I have a right to revoke this Authorization at any time, provided that my revocations in writing. I understand that I have a right to receive a copy. I further understand that if the information provided by this Authorization is disclosed (given) to another person or agency, it may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving the health information by this Authorization to disclose it, unless a new Authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

IEHP will act on this request within 30 days of the date the Authorization was received, or within 60 days if the requested information is not maintained or accessible to IEHP on-site.

---

**Please complete all required sections, sign and return this Authorization to:**

Inland Empire Health Plan | Attn: Legal Department
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-477-8578 | Email: Legal@iehp.org

---

**OPTIONAL**

**Specific Authorizations:**

PHI records of substance abuse, mental health conditions, and HIV information will not be disclosed without specific authorization. If you request the use and disclosure of such records, please give specific authorization by initialing in the appropriate box(es) below:

- Drug/Alcohol Abuse Treatment Information
- Mental Health Treatment Information *(does NOT include psychotherapy notes)*
- HIV Test Results and Treatment Information
- Other

---

**REQUIRED**

**Delivery Options: (please check one)**

- Pick-up at IEHP (Monday – Friday, 8am - 11am and 1pm - 4pm)*
  * If you choose to pick up your records, the IEHP Legal Department will contact you when your records are available. Your records will be available for pick up for 14 business days. If your records are not picked up within 14 business days, they will be destroyed.

- FedEx Delivery
  Delivery Address

- Secure E-mail Portal*
  E-mail Address
  * In order to protect your privacy, IEHP delivers PHI using a secure e-mail portal. Upon request, IEHP can deliver your PHI using an unencrypted and unsecure e-mail portal. However, IEHP is not responsible or liable for breaches that may occur if PHI is sent using an unencrypted and unsecure e-mail. If you are requesting IEHP deliver your PHI using an unencrypted and unsecure e-mail portal, and accept the security risks with using this method, please initial here ______.

**If delivering to a person/entity other than yourself or your legal representative, please state the name and contact information of the person/entity authorized to receive your PHI records:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Member</th>
</tr>
</thead>
</table>

---

**SPECIFIC AUTHORIZATIONS**

PHI records of substance abuse, mental health conditions, and HIV information will not be disclosed without specific authorization. If you request the use and disclosure of such records, please give specific authorization by initialing in the appropriate box(es) below:

- Drug/Alcohol Abuse Treatment Information
- Mental Health Treatment Information *(does NOT include psychotherapy notes)*
- HIV Test Results and Treatment Information
- Other

---

**OPTIONAL**

**SPECIFIC AUTHORIZATIONS**

PHI records of substance abuse, mental health conditions, and HIV information will not be disclosed without specific authorization. If you request the use and disclosure of such records, please give specific authorization by initialing in the appropriate box(es) below:

- Drug/Alcohol Abuse Treatment Information
- Mental Health Treatment Information *(does NOT include psychotherapy notes)*
- HIV Test Results and Treatment Information
- Other

---

**DISCLOSURES**

Please complete all required sections, sign and return this Authorization to:

Inland Empire Health Plan | Attn: Legal Department
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-477-8578 | Email: Legal@iehp.org

---

**FOR INTERNAL USE ONLY**

Authorization contains Privileged and Confidential Information.

Rev. 7/2016

Page 2 of 2
La Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act, HIPAA), los reglamentos federales y la legislación de California requieren que se llene esta Autorización para autorizar a Inland Empire Health Plan (IEHP) a usar y divulgar Información Protegida de Salud (Protected Health Information, PHI).

Yo __________________________ autorizo a IEHP a usar o divulgar la PHI de este Miembro, como se describe a continuación:

<table>
<thead>
<tr>
<th>OBLIGATORIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Miembro</td>
</tr>
<tr>
<td>Domicilio (para la entrega)</td>
</tr>
<tr>
<td>Ciudad</td>
</tr>
</tbody>
</table>

Por favor, indique el tipo de registros de PHI que solicita:*

- [ ] Administración de la Atención Médica
- [ ] Administración de Casos de Apelaciones y Quejas
- [ ] Inscripción / Elegibilidad
- [ ] Referencias / Autorizaciones
- [ ] Receta
- [ ] Reclamaciones / Facturación

Ingresé el intervalo de fechas de los registros de PHI solicitados: de ___ / ___ / ___ a ___ / ___ / ___

**Indique los motivos para divulgar o usar PHI:**

- [ ] Legal
- [ ] Uso personal
- [ ] Seguro médico
- [ ] Otro (Especifique) ___________________________________________________________________

*IEHP no conserva registros médicos o clínicos individuales. Estos registros están bajo custodia de profesionales/entidades que proporcionaron los servicios médicos, es decir, Doctores de Cuidado Primario, Especialistas, Hospitales, etcétera.

Leí esta Autorización y acepto el uso y la divulgación de la PHI, tal como se especifica.

<table>
<thead>
<tr>
<th>OBLIGATORIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Miembro (en letra de imprenta)</td>
</tr>
</tbody>
</table>

Si firma a nombre del Miembro, describa su autoridad para actuar en nombre del Miembro (por ejemplo, es padre o madre de un hijo menor de edad, o tutor legal):

________________________________________________________________________

Nota: La documentación adecuada de la autoridad del representante legal debe estar registrada en IEHP.

<table>
<thead>
<tr>
<th>OBLIGATORIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Representante Legal del Miembro (en letra de imprenta)</td>
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</tbody>
</table>

Esta Autorización entra en vigencia inmediatamente y seguirá vigente hasta el _______________ (fecha de finalización)
## Autorización de Divulgación

### Autorizaciones Específicas:

Los registros de PHI sobre abuso de sustancias, condiciones de salud mental e información sobre el VIH no se divulgarán sin autorización específica. Si usted solicita el uso y la divulgación de dichos registros, por favor, ponga sus iniciales en las casillas adecuadas a continuación para dar su autorización específica:

- [ ] Información de Tratamiento de Abuso de Drogas/Alcohol
- [ ] Información de Tratamiento de Salud Mental (esto NO incluye apuntes de psicoterapia)
- [ ] Información de Resultados y Tratamiento de VIH
- [ ] Otro __________

### Opciones de Entrega: (por favor, marque una)

- [ ] Recoger en IEHP (de lunes a viernes, de 8 a.m. a 11 a.m. y de 1 p.m. a 4 p.m.)*
  - Si elige recoger sus registros, el Departamento Legal de IEHP se pondrá en contacto con usted cuando los registros estén disponibles. Sus registros estarán disponibles para que los recoja durante 14 días hábiles. Si sus registros no se recogen en el plazo de 14 días hábiles, serán destruidos.

- [ ] Envío por FedEx
  - Domicilio de Entrega __________

- [ ] Portal de Correo Electrónico Seguro*
  - Dirección de Correo Electrónico __________
  - * Para proteger su privacidad, IEHP envía PHI a través de un portal de correo electrónico seguro. Cuando lo solicite, IEHP puede enviar su PHI a través de un portal de correo electrónico no cifrado y no seguro. Sin embargo, IEHP no se hace responsable de violaciones que pudieran ocurrir si la PHI se envía a través de un correo electrónico no cifrado y no seguro. Si va a solicitar que IEHP le envíe su PHI por medio de un portal de correo electrónico no cifrado y no seguro, y si acepta los riesgos de seguridad con este método, ponga sus iniciales aquí __________.

Si la entrega se hará a una persona/entidad que no sea usted o su representante legal, por favor, indique el nombre y la información de contacto de la persona/entidad autorizada para recibir sus registros de PHI:

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Relación con el Miembro</th>
</tr>
</thead>
</table>

### Información de Contacto para la Entrega (si es diferente a la anterior)

### Aviso sobre los Derechos y Otra Información

Estoy consciente de que no tengo que firmar esta Autorización. El hecho de que me niegue a firmarla no afectará mi capacidad para obtener tratamiento, un pago o la elegibilidad para recibir beneficios. Entiendo que tengo derecho a revocar esta Autorización en cualquier momento, siempre y cuando mis revocaciones sean por escrito. Entiendo que tengo derecho a recibir una copia. Además, entiendo que si la información proporcionada en esta Autorización se divulga (se da) a otra persona o agencia, es posible que ya no esté protegida por la ley federal de confidencialidad (HIPAA). Sin embargo, la legislación de California no permite que la persona que reciba la información médica por medio de esta Autorización la divulgue, a menos que yo otorgue una nueva autorización para tal divulgación, o a menos que la ley requiera o permita específicamente tal divulgación. IEHP trabajará en esta solicitud en un plazo de 30 días desde la fecha en que se recibió la Autorización, o en un plazo de 60 días si la información solicitada no se mantiene o está accesible para IEHP en sus instalaciones.

**Por favor, llené, firme y devuelva esta Autorización a:**

Inland Empire Health Plan | Attn: Legal Department
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-477-8578 | Correo electrónico: Legal@iehp.org

EXCLUSIVAMENTE PARA USO INTERNO
La autorización contiene Información Privilegiada y Confidencial.

Rev. 7/2016
The California Prenatal Screening Program

Sequential Integrated Screening
First and second trimester blood test results combined with Nuchal Translucency

Serum Integrated Screening
Combines first trimester blood test results with second trimester blood test results

Quad Marker Screening
One blood specimen drawn second trimester (15 weeks-20 weeks)
The California Prenatal Screening Program is voluntary. Women can refuse testing without losing insurance benefits or eligibility or services from State Programs.

California law prohibits the use of test results by insurance companies or employers to discriminate against an individual. If you believe that you have experienced discrimination as a result of prenatal screening, write to Chief of the Genetic Disease Screening Program, at the address below.

California Department of Public Health
Genetic Disease Screening Program
850 Marina Bay Parkway, F175
Richmond, CA 94804
866-718-7915 toll free

For more information visit our website: www.cdph.ca.gov or email us: pns@cdph.ca.gov

March 2017
The California Prenatal Screening Program

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The California Prenatal Screening Program

Checking a Baby’s Health Before Birth

During pregnancy, it is important to know as much as possible about the health of the developing baby. For some women, this means testing for birth defects. Babies can be born with birth defects even when the mother is healthy. The California Prenatal Screening Program can help detect some birth defects such as:

- Down syndrome: a cause of intellectual disability
- Trisomy 18: intellectual disability and severe physical birth defects
- Trisomy 13: intellectual disability and severe physical birth defects
- Neural tube defects: such as spina bifida (open spine)
- Abdominal wall defects: the baby’s intestines are outside the body
- Smith-Lemli-Opitz syndrome: SLOS is a very rare condition causing intellectual disability and physical birth defects

A screening test estimates the chance (risk) that the baby has certain birth defects. This is called a “Risk Assessment”. If the risk is high, a woman may then choose to have advanced screening or diagnostic tests that confirm or rule out most birth defects.

See pages 9-10 for a description of these birth defects

REMEMBER, it is a woman's decision whether to have prenatal screening tests. A Consent or Decline form is on pages 14-17.
Blood Tests are Part of Prenatal Screening

A small amount of blood is taken from the pregnant woman’s arm and sent to the Program. At different times during pregnancy, her blood is tested for substances such as:

- PAPP-A ....... Pregnancy Associated Plasma Protein A
- hCG ............. Human Chorionic Gonadotropin
- AFP ............ Alpha-Fetoprotein
- uE3 ............ Unconjugated Estriol
- Inhibin .......... Dimeric Inhibin-A (DIA)

These substances are made by the pregnant woman and her unborn baby. At each week of pregnancy, there are different expected amounts of these substances in the mother’s blood. Other information used for the screening test includes age, race and weight.

Blood test results are sent to a woman’s doctor or clinic 7 to 10 days after blood draw.

Based on her week of pregnancy, a woman and her doctor can choose which type of screening is best for her.

Screening Timeline

<table>
<thead>
<tr>
<th>First Trimester Blood Draw</th>
<th>Second Trimester Blood Draw</th>
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<tr>
<td>... 9 10 11 12 13 14</td>
<td>15 16 17 18 19 20 ...40 weeks</td>
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</table>

Nuchal Translucency

Gestation in Weeks
The California Prenatal Screening Program Offers Three Types of Screening Tests

Sequential Integrated Screening

First Trimester Risk Assessment
A first trimester blood specimen is drawn at 10 weeks 0 days – 13 weeks 6 days of pregnancy. A Nuchal Translucency*(NT) ultrasound is done between 11 weeks 2 days and 14 weeks 2 days of pregnancy. A preliminary risk assessment is provided for Down syndrome and Trisomy 18.

Second Trimester Risk Assessment
A second trimester blood specimen is drawn at 15 weeks 0 days – 20 weeks 0 days of pregnancy. These test results are combined with the first trimester test results and NT ultrasound. New risk assessment is provided for Down syndrome and Trisomy 18. Risk assessment is also provided for neural tube defects and SLOS.

Serum Integrated Screening (No NT ultrasound)
A first trimester blood specimen is drawn at 10 weeks 0 days – 13 weeks 6 days of pregnancy. A second trimester blood test is drawn at 15 weeks – 20 weeks. The results of the two blood tests are combined. Risk assessment is reported, only in the second trimester, for Down syndrome, Trisomy 18, neural tube defects and SLOS.

Quad Marker Screening
One blood specimen is drawn at 15 weeks – 20 weeks of pregnancy (second trimester). Risk assessment is reported in the second trimester for Down syndrome, Trisomy 18, neural tube defects and SLOS.

*Nuchal Translucency (NT)* - A type of ultrasound done only by doctors or technicians with special training. It measures the fluid at the back of the baby's neck. All babies have a collection of fluid, but babies with Down syndrome and Trisomy 18 tend to have more.

You should talk to your doctor about where to go for Nuchal Translucency Ultrasound. Also talk to your insurance about coverage. This special ultrasound is not provided by the Prenatal Screening Program.
<table>
<thead>
<tr>
<th>Name of Screening Test</th>
<th>Test Type</th>
<th>When the Test is Done</th>
<th>Detection Rates</th>
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<tbody>
<tr>
<td>Sequential Integrated Screening</td>
<td>Two Blood Draws +</td>
<td>First blood draw between 10 weeks to 13 weeks 6 days of pregnancy.</td>
<td>90 out of 100</td>
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<td></td>
<td>Nuchal Translucency Ultrasound</td>
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<td>Second blood draw between 15 to 20 weeks of pregnancy.</td>
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<td><strong>Down syndrome</strong></td>
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<td><strong>anencephaly</strong></td>
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<td><strong>open spina bifida</strong></td>
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<td><strong>abdominal wall defects</strong></td>
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<td><strong>SLOS</strong></td>
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<tr>
<td>Serum Integrated Screening</td>
<td>Two Blood Draws</td>
<td>First blood draw between 10 weeks to 13 weeks 6 days of pregnancy.</td>
<td>85 out of 100</td>
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<td></td>
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<td>Second blood draw between 15 to 20 weeks of pregnancy.</td>
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<td><strong>SLOS</strong></td>
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</tr>
<tr>
<td>Quad Marker Screening</td>
<td>One Blood Draw</td>
<td>Between 15 to 20 weeks of pregnancy</td>
<td>80 out of 100</td>
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<td></td>
<td><strong>SLOS</strong></td>
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</table>

Based on your week of pregnancy, you and your doctor can choose which type of screening is best for you.
The Types of Screening Results

*Your results are specific to you and your current pregnancy.*

**Result: Preliminary Risk Assessment** - This first trimester result means that the risk (chance) of the baby having Down syndrome or Trisomy 18 is low.... low enough that the Program does not offer follow-up tests.

Result: Screen Negative - This second trimester result means that the risk (chance) of the baby having any of the screened birth defects is low.... low enough that the Program does not offer follow-up tests.

**Important:** A result of *Screen Negative* or *Preliminary Risk Assessment* does not guarantee that there are no birth defects. Prenatal Screening tests *cannot* detect 100% of these birth defects.

See Chart on page 5 to compare detection rates of the three types of prenatal screening tests.

**Result: Screen Positive** - This means that the risk (chance) of the baby having any of these birth defects is higher than usual. The Program offers follow-up tests to look for possible birth defects.

**Important:** A result of *Screen Positive* does not always mean that there is a birth defect.

Most women with a screen positive result will have normal follow-up diagnostic tests and healthy babies.
Test Results and Follow-Up Services

If any test is Screen Positive, what happens next?

A woman with a Screen Positive result will be called by her doctor or clinic. She will be offered follow up services at a State-approved Prenatal Diagnosis Center up to 24 weeks of pregnancy. Authorized services are free at a State-approved Prenatal Diagnosis Center.

A woman can decline services at any time. She can accept some services such as genetic counseling, and decline other services at the Prenatal Diagnosis Center.

◆ Genetic Counseling: The first service a woman receives at the Prenatal Diagnosis Center is genetic counseling. A Genetic Counselor explains the test results and reviews the family medical history. The counselor explains the follow-up tests which may be offered.

A Genetic Counselor helps a woman decide whether to have diagnostic testing.
Tests Which May be Offered After Genetic Counseling:

◆ **Prenatal Cell-free DNA (cfDNA) Screening:**  
This is a blood test using fetal DNA that is found in the mother’s blood. Prenatal cfDNA screening is considered to be a very accurate screening test for certain chromosome abnormalities like Down syndrome and Trisomy 18. This test is offered at 10 weeks - 24 weeks of pregnancy.

◆ **CVS (Chorionic Villus Sampling):** This may be offered at 10-14 weeks of pregnancy. An experienced State-approved doctor takes a small number of cells from the placenta. These cells are tested for Down syndrome, Trisomy 18, and other chromosome abnormalities.

◆ **Ultrasound:** A detailed picture of the baby is made using sound waves. After 15 weeks of pregnancy, a doctor examines the baby very closely for birth defects.

◆ **Amniocentesis:** This may be offered after 15 weeks of pregnancy. An experienced State-approved doctor takes a small amount of fluid from around the baby. Tests are done for specific birth defects and for Down syndrome, Trisomy 18 and other chromosome abnormalities.
Birth Defects Found Through Diagnostic Testing

Down Syndrome

Down syndrome is caused by an extra chromosome #21 (Trisomy 21). Chromosomes are packages of genetic material found in every cell of the body. Birth defects can occur when there are too few or too many chromosomes.

Down syndrome is a common cause of intellectual disability and birth defects. Down syndrome can affect babies born to women of any age. However, as women get older, the chances increase for having a baby with Down Syndrome.

Trisomy 18

Trisomy 18 is caused by an extra chromosome #18. Most babies with Trisomy 18 are lost through miscarriage. Babies born with Trisomy 18 have intellectual disability and physical defects.

Trisomy 13

Trisomy 13 is caused by an extra chromosome #13. Most babies with Trisomy 13 are lost through miscarriage. Babies born with Trisomy 13 have intellectual disability and severe physical birth defects.

Smith-Lemli-Opitz Syndrome (SLOS), SCD

This is a very rare birth defect. Babies born with Smith-Lemli-Opitz syndrome (SLOS) cannot make cholesterol normally. Babies born with this condition have intellectual disability and may have many physical defects.

Screen Positive results for SLOS can also indicate increased chances for Congenital abnormalities and fetal Demise (fetal death). That is why this screening is also called SCD screening.
Neural Tube Defects (NTD)

As a baby is forming, the neural tube extends from the top of the head to the end of the spine. This develops into the baby's brain and spinal cord. The neural tube is completely formed by 5 weeks after conception.

When there is an opening in the spine, it is called spina bifida. This defect often causes paralysis of the baby's legs. It may also cause loss of bowel and bladder control.

Anencephaly occurs when most of the brain does not develop. This defect causes the death of the baby or newborn.

Abdominal Wall Defects

Abdominal Wall Defects (AWD) are problems involving the baby's abdomen and intestines. These defects happen when the intestines and other organs are outside the body. Surgery after birth is usually performed to correct the defect.

What if diagnostic tests show that the baby has a birth defect?

Information will be given to the woman by a doctor or genetic counselor at the Prenatal Diagnosis Center. They will discuss the birth defect, and options for the pregnancy. The Program does not pay for any other medical services after the diagnostic tests. Referrals for special support services for special needs babies are available.

There are other birth defects which cannot be detected by the Program.
Diagnostic Tests Instead of Screening Tests for Birth Defects

Some women may consider diagnostic tests instead of screening tests. A diagnostic test can tell whether or not the baby actually has a specific birth defect. Screening estimates the risk of certain birth defects.

Diagnostic tests during pregnancy can include amniocentesis or chorionic villus sampling (CVS). Diagnostic tests done instead of screening tests are not covered by the Program.

Who may want to consider diagnostic testing instead of screening?

- women with a medical or family history of inherited conditions
- women who know that the baby's father has a medical or family history of inherited conditions
- women who are taking certain medicines
- women who have diabetes prior to pregnancy
- women with other high risk pregnancies
- women age 35 and older at delivery

Before deciding between a screening test and a diagnostic test, you should talk to your doctor or a genetic counselor. Some insurance policies may cover genetic counseling. Ask your doctor for the pamphlet "Prenatal Diagnosis".
Program Fee

What is the fee for the Prenatal Screening Program?

Presently, the fee is $221.60. Check with your doctor or clinic about the current fee. **The fee covers the blood tests and authorized follow-up services at a State-approved Prenatal Diagnosis Center.**

The Program charges $221.60 when:

- there is one blood test or two
- there is one baby or two.

**The Program fee does not cover:**

- blood draw charges
- nuchal translucency ultrasound

The Program mails a bill and insurance form to the patient unless insurance information is received with the blood specimen. In most cases, health insurance companies and HMOs are required to cover the fees for the screening program after any deductible or co-pay. There is an exception made for self-insured employers. Medi-Cal covers the Program fee.

Contact your health insurance provider to determine your plan's payment or co-pay for prenatal testing.
Consent

Please talk to your doctor about the screening tests described in this booklet. If you decide to participate in Prenatal Screening, you do not need to consent to any specific type of blood screening test. You only need to consent to participate in the Prenatal Screening Program. Or, you can decline to participate in the Program.

To document either choice, you will need to sign the Consent or Decline form on the next page.

Research

The California Birth Defects Monitoring Program was created to collect information on birth defects. This Program helps researchers to identify the causes of birth defects and other health problems of women and children.

The Birth Defects Monitoring Program and the Prenatal Screening Program are both part of the California Department of Public Health. After screening is completed, the Prenatal Screening Program saves some blood specimens and stores them with the Birth Defects Monitoring Program.

The Department of Public Health must approve any research and any use of these specimens by the Birth Defects Monitoring Program. The Department maintains your confidentiality under the laws and regulations that apply.

The prenatal screening specimens are valuable for research about the causes and prevention of birth defects. However, you can have prenatal screening and decline the use of your specimen for research through a check box on the consent form. Declining research will not affect your health care or test results in any way.
Consent or Decline
California Prenatal Screening Program

1. I have read the information in this booklet (or have had it read to me).

2. I understand that:
   
a. The Prenatal Screening Program offers prenatal tests for the detection of birth defects such as Down syndrome, Trisomy 18, Trisomy 13, Smith-Lemli-Opitz syndrome (SLOS), Neural Tube Defects, and Abdominal Wall Defects. These birth defects cannot be detected 100% of the time.

b. There is a Program fee charged to the patient. This fee may be covered by health insurance. I agree to pay any part of this fee not covered by insurance.

c. If the blood test result is Screen Negative, the Program will not pay for any follow-up testing.

d. If the blood test result is Screen Positive, I will need to make a decision regarding follow-up diagnostic testing.

e. If the baby is found to have a birth defect, the decision to continue or terminate the pregnancy is entirely mine.

f. There are birth defects that cannot be detected with screening tests.

3. I also understand that:
   
a. Participation in the Prenatal Screening Program is voluntary. I can decline any test at any time.

b. Consent to participate in the Program may include Quad, Serum or Sequential Integrated Screening.
Yes
I Consent to Screening

I consent to participate in the California Prenatal Screening Program. I request that blood be drawn for Prenatal Screening.

I agree that my blood specimen may be used for research by the Department of Public Health, or Department approved researchers, unless I mark the box below.

☐ I decline the use of my specimen for research.

The Department will maintain confidentiality according to applicable laws and regulations.

Signed__________________________ Date____________

No
I Decline Screening

I decline to participate in the California Prenatal Screening Program. I request that blood not be drawn for Prenatal Screening.

Signed__________________________ Date____________
Consent or Decline
California Prenatal Screening Program

1. I have read the information in this booklet (or have had it read to me).

2. I understand that:
   
   a. The Prenatal Screening Program offers prenatal tests for the detection of birth defects such as Down syndrome, Trisomy 18, Trisomy 13, Smith-Lemli-Opitz syndrome (SLOS), Neural Tube Defects, and Abdominal Wall Defects. These birth defects cannot be detected 100% of the time.

   b. There is a Program fee charged to the patient. This fee may be covered by health insurance. I agree to pay any part of this fee not covered by insurance.

   c. If the blood test result is Screen Negative, the Program will not pay for any follow-up testing.

   d. If the blood test result is Screen Positive, I will need to make a decision regarding follow-up diagnostic testing.

   e. If the baby is found to have a birth defect, the decision to continue or terminate the pregnancy is entirely mine.

   f. There are birth defects that cannot be detected with screening tests.

3. I also understand that:
   
   a. Participation in the Prenatal Screening Program is voluntary. I can decline any test at any time.

   b. Consent to participate in the Program may include Quad, Serum or Sequential Integrated Screening.
| **Yes** | I consent to participate in the California Prenatal Screening Program. I request that blood be drawn for Prenatal Screening.  
I agree that my blood specimen may be used for research by the Department of Public Health, or Department approved researchers, unless I mark the box below.  
☐ I decline the use of my specimen for research.  
The Department will maintain confidentiality according to applicable laws and regulations.  
Signed __________________________ Date ____________ |
|---|---|
| **No** | I decline to participate in the California Prenatal Screening Program. I request that blood not be drawn for Prenatal Screening.  
Signed __________________________ Date ____________ |
Environmental Health Information

Reproductive Health and the Environment

We encounter chemicals and other substances in everyday life that may affect your developing baby. Fortunately, there are steps you can take to reduce your exposure to these potentially harmful substances at home, in the workplace, and in the environment. Many Californians are unaware that a number of everyday consumer products may pose potential harm. Prospective parents should talk to their doctor and are encouraged to read more about this topic to learn about simple actions to promote a healthy pregnancy.

At the University of California, San Francisco, the Program on Reproductive Health and the Environment produces *All That Matters* brochures. These are nontechnical, patient-centered guides that provide tips and suggestions for avoiding toxic chemical exposure at home, in the workplace and in the community. These resources include:

- **Toxic Matters** – Provides tips on avoiding chemicals for pregnant women and women who want to become pregnant.
- **Cuestiones de Salud** – a Spanish language edition of Toxic Matters.
- **Work Matters** – Explains how to prevent toxic exposures in the workplace, and how pregnant women can secure their rights to a safe and healthy work environment.
- **Food Matters: What to Eat?** – Explains how to select foods with lower exposure to toxic chemicals.
- **Pesticides Matter** – Provides tips on avoiding exposure to pesticides at work and at home and how to protect one’s family.

The All That Matters brochures are available online at: [http://prhe.ucsf.edu/prhe/allthatmatters.html](http://prhe.ucsf.edu/prhe/allthatmatters.html)

For a more detailed resource, the American Academy of Pediatrics produces *Pediatric Environmental Health*. This book provides comprehensive information on a wide range of environmental health issues.
Information About Cord Blood Banking

As a pregnant woman gets closer to her delivery date, the option of saving the baby's cord blood can be considered. Newborn umbilical cord blood contains stem cells which may be used to treat people with certain blood-related disorders. These include some types of cancer, immune system disorders, and genetic diseases.

Newborn cord blood can be collected from the umbilical cord shortly after birth. This does not interfere with the birthing process. It does not harm the health of either the baby or the mother. The collection of cord blood is safe, quick, and painless. If not collected, cord blood is discarded as medical waste.

Parents may choose to have their newborn's umbilical cord blood donated to a public cord blood bank. This donated cord blood can be made available to anyone who may need a blood stem cell transplant. It may also be made available to researchers who are trying to discover the causes of birth defects and other health-related problems. There is no cost for publicly donating cord blood.

Parents may instead choose to store their newborn's umbilical cord blood at a private cord blood bank. This cord blood could possibly be used if a compatible family member requires a blood stem cell transplant. There are fees for collecting and storing cord blood at a private cord blood bank.

Both private and public cord blood banks are available in California. Parents interested in donating their baby's cord blood should talk with their prenatal care provider by the 34th week of pregnancy, or earlier.

For more information on both public and private cord blood banking, visit or call:

- National Cord Blood Program:
  [www.nationalcordbloodprogram.org](http://www.nationalcordbloodprogram.org); 866-767-6227
- National Marrow Donor Program:
  [www.bethematch.org](http://www.bethematch.org); 800-627-7692
NOTICE OF PRIVACY PRACTICES
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
GENETIC DISEASE SCREENING PROGRAM,
THE CALIFORNIA PRENATAL SCREENING
PROGRAM EFFECTIVE DATE: July, 2015

THIS NOTICE DESCRIBES HOW MEDICAL AND OTHER PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Department’s Legal Duties.** The Genetic Disease screening program is required by law to maintain the privacy of protected health information. Th e Federal and State laws restrict the use, maintenance and, disclosure of personal information obtained by a State agency, and require certain notices to individuals whose information is maintained. Th e law also requires us to let you know promptly if a the privacy or security of your breach occured that may have compromised information. State laws include the California Information Practices Act (Civil Code 1798 et seq.), Government Code Section 11015.5 and Health and Safety Code Section 124980. Th e federal law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d-2(a)(2), and its regulations in Title 45 Code of Federal Regulations Sections 160.100 et seq. In compliance with these laws, you and those providing information are notified of the following:

**Department Authority and Purpose for the Prenatal Screening**
The Department of Public Health Program collects and uses personal and medical information as permitted in Health and Safety Code Sections 124977, 124980, 125000, 125002,125050, 125055, and 123055, and according to procedures in State regulations (17 CCR 6527, 6529, 6531 and 6532). It is used to estimate the risk of serious birth defects in the pregnancy and provide diagnostic testing for pregnant women.

If personal information is not provided, problems could result such as not detecting an affected baby, falsely reporting increased risk causing unnecessary invasive testing, or not being able to bill properly for the services provided. This information is collected electronically and includes such things as your name, address, testing results, and medical care given to you.

**Uses and Disclosure of Health Information.** The Department of Public Health uses health information about you for screening, to provide health care services, to obtain payment for screening, for administrative purposes, and to evaluate the quality of care that you receive. Some of this information is retained for as long as 21 years. The information will not be sold. The law also allows the Department to use or give out information we have about you for the following reasons:
For research studies, that have been approved by an institutional review board and meet all federal and state privacy law requirements, such as research related to preventing disease.

For medical research without identification of the person from whom the information was obtained, unless you specifically request in writing that your information not be used, by writing to the address listed below.

To organizations which help us in our operations, such as by collecting fees. If we provide them with information, we will make sure that they protect the privacy of information we share with them as required by Federal and State law.

The Genetic Disease Program must have your written permission to use or give out personal and health information about you for any reason that is not described in this notice. You can revoke your authorization at any time, except if the Genetic Disease Screening Program has already acted because of your permission by contacting the Chief of the Genetic Disease Screening Program at:

850 Marina Bay Parkway, F175, Richmond, CA 94804

The Department reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. The most current Privacy Notice can be found at the Prenatal Screening Program website: www.cdph.ca.gov/programs/pns. You may request a copy of the current policies or obtain more information about our privacy practices, by calling the numbers listed on the next page or consulting the Program website. You may also request a paper copy of this Notice. This Privacy Notice can also be found at the website: www.ca.gov/programs/pages/Privacyoffice.aspx.

Individual Rights and Access to Information. You have the right to look at or receive a copy of your health information. If you request copies, we will charge you $0.10 (10 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than screening, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You have the right to ask us to contact you at a different address, post office box or telephone number. We will accept reasonable requests.

You may request in writing that we restrict disclosure of your information for health care treatment, payment and administrative purposes, however we may not be able to comply with your request.

Complaints. If you believe that we have not protected your privacy or have violated any of your rights and wish to file a complaint, please call or write to the:
Privacy Officer, CA Department of Public Health, 1415 L Street, Suite 500, Sacramento, CA 95814, (916) 440-7671 or (877) 421-9634 TTY/TDD.

You may also contact the United States Department of Health and Human Services, Attention: Regional Manager, Office for Civil Rights at 90 7th Street, Suite 4-100, San Francisco, CA 94103, telephone (800) 368-1019, or the U.S. Office of Civil Rights at 866-OCR-PRIV (866-627-7748) or 866-788-4989 TTY.

The Department cannot take away your health care benefits or any other protected rights in any way if you choose to file a complaint or use any of the privacy rights in this notice.

Department Contact – The information on this form is maintained by the Department of Public Health, Genetic Disease Screening Program. The Chief of the Genetic Disease Screening Program may be reached at 850 Marina Bay Parkway, F175, Richmond, California, 94804, (510) 412-1502. The Chief is responsible for the system of records and shall, upon request, inform you about the location of your records and respond to any requests you may have about information in those records.

AMERICANS WITH DISABILITIES ACT (ADA)
Notice of Information and Access Statement
Policy of Nondiscrimination on the Basis of Disability and Equal Employment Opportunity Statement

The California Department of Public Health (CDPH) complies with all state and federal laws, which prohibit discrimination in employment and provide admission and access to its programs or activities.

The Deputy Director, Office of Civil Rights (OCR), CDPH has been designated to coordinate and carry out the department's compliance with nondiscrimination requirements. Title II of the ADA addresses nondiscrimination and access issues regarding disabilities. To obtain information concerning the CDPH EEO Policies or the provisions of the ADA and the rights provided, you may contact the CDPH OCR by phone at 916-440-7370, TTY 916-440-7399 or write to:

OCR, CA Dept. of Public Health
MS0009, P.O. Box 997413
Sacramento, CA 95899-7413

Upon request, this document will be made available in Braille, high contrast, large print, audiocassette or electronic format. To obtain a copy in one of these alternate formats, call or write:

Chief, Prenatal Screening Branch
850 Marina Bay Pkwy, F175, Mail Stop 8200, Richmond, CA 94804 Phone: 510-412-1502 Relay Operator 711/1-800-735-2929
The California Newborn Screening Test

Newborn screening can prevent serious health problems or even save your baby's life. Newborn screening can identify babies with certain diseases so that treatment can be started right away. Early identification and treatment can prevent intellectual disability and/or life-threatening illness.

What Types of Diseases are Screened for in California?

To protect the health of all newborns, California state law requires that all babies must have the Newborn Screening (NBS) Test before leaving the hospital. The test screens for specific diseases in the following groups:

- **Metabolic diseases** - affect the body's ability to use certain parts of food; for growth, energy and repair.
- **Endocrine diseases** - babies make too much or too little of certain hormones that affect body functions.
- **Hemoglobin diseases** - affect the type and amount of hemoglobin in red blood cells, often leading to anemia and other problems.
- **Other genetic diseases** - Cystic Fibrosis, Severe Combined Immunodeficiency (SCID), Adrenoleukodystrophy (ALD).

How is the Test Done and Who Pays for it?

A few drops of blood taken from the baby's heel are put on special filter paper. Medi-Cal, health plans, and most private insurance will pay for the test. The cost is included in the hospital bill.

Make Sure You Get This Booklet!

Make sure you get the booklet "Important Information for Parents About the Newborn Screening Test" from your prenatal care provider or go to our website at www.cdph.ca.gov/nbs.
## INLAND EMPIRE HEALTH PLAN
### COMBINED 2nd TRIMESTER REASSESSMENT

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
<th>EDC</th>
<th>Date</th>
</tr>
</thead>
</table>

### ANTHROPOMETRIC
- **WT. GRID PLOTTED**
  - Wt. this visit: [ ]
  - Gain Since Last Visit: [ ]
  - Comment: [ ]

### Substance Abuse:
- 12. Are you smoking at all? [ ]
  - If YES, how many cigarettes per day? [ ]
- 13. How often do you drink beer, wine, or liquor? [ ]
- 14. What drugs have you used since becoming pregnant? [ ]

### BIOCHEMICAL
- **Blood**
  - Date Collected: [ ]
  - Hemoglobin: [ ]
  - MCV: [ ]
  - Glucose: [ ]
- **Urine**
  - Date Collected: [ ]
  - Glucose: [ ]
  - Ketones: [ ]

### CURRENT CLINICAL
- **Labor and Delivery**
  - 15. Have you had a hospital tour? [ ]
  - 16. Do you need information about what will happen during labor and delivery? [ ]

### NUTRITION
- **Infant Feeding**
  - 6. How do you plan to feed your baby? [ ]
    - Breast [ ]
    - Bottle [ ]
    - Both [ ]
    - Not Sure [ ]
  - 7. Have you breastfed a baby before? [ ]
    - If YES, how long did you breastfeed? [ ]

### PSYCHOSOCIAL
- 17. Where are you living right now? [ ]
- 18. How many people are living with you? [ ]
- 19. If you are worried about something, who do you talk to? [ ]
- 20. Do you have: [ ]
  - electricity [ ]
  - hot water [ ]
  - telephone [ ]
  - transportation [ ]
  - heating [ ]
  - refrigerator [ ]
  - stove/oven [ ]
- 21. Are you able to buy enough food? [ ]
- 22. Are you able to pay your rent? [ ]
- 23. Are you able to pay your other bills? [ ]
- 24. How do you feel about this pregnancy? [ ]
- 25. Since becoming pregnant, have you had? [ ]
  - trouble sleeping [ ]
  - sadness [ ]
  - worried feelings [ ]
  - crying [ ]
  - depression [ ]
  - sadness [ ]
  - none [ ]
  - other [ ]
- 26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? [ ]

### REFERRALS:
- [ ] WIC Date enrolled __________
- [ ] Car Seat Class Date Attended __________

### MATERIALS GIVEN:
- [ ] Family Planning
- [ ] Infant Feeding
- [ ] Other

### ASSESSMENT SUMMARY:

Reviewed By: [ ]

Next Assessment Date: __________

---

For Provider Use Only

Prenatal Care Provider: [ ]

IEHP Member Number: [ ]

IEHP Provider Number: [ ]
# INLAND EMPIRE HEALTH PLAN
## COMBINED 3rd TRIMESTER REASSESSMENT

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
<th>EDC</th>
<th>Date</th>
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</table>

### ANTHROPOMETRIC
- **WT. GRID PLOTTED**
- **Gain Since Last Visit**
- **Comment**

<table>
<thead>
<tr>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Are you smoking at all?</td>
</tr>
<tr>
<td>If YES, how many cigarettes per day?</td>
</tr>
<tr>
<td>13. How often do you drink beer, wine, or liquor?</td>
</tr>
<tr>
<td>14. What drugs have you used since becoming pregnant?</td>
</tr>
</tbody>
</table>

### BIOCHEMICAL
- **Blood**
- **Hemoglobin:** H L
- **Hematocrit:** H L
- **MCV:** H L
- **Albumin:** H L
- **Glucose:** H L
- **GTT:** H L

### CURRENT CLINICAL
- **Blood Pressure:**
- **Edema:**
- **Y N**

<table>
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<tr>
<th>Labor and Delivery</th>
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<tr>
<td>15. Have you had a hospital tour</td>
</tr>
<tr>
<td>16. Do you need information about what will happen during labor and delivery?</td>
</tr>
</tbody>
</table>

### NUTRITION
- **Dietary Assessment**
- **24 hour recall completed**

<table>
<thead>
<tr>
<th>Infant Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. How do you plan to feed your baby?</td>
</tr>
<tr>
<td>7. Have you breastfed a baby before?</td>
</tr>
<tr>
<td>If YES, how long did you breastfeed?</td>
</tr>
</tbody>
</table>

### PSYCHOSOCIAL
- **Where are you living right now?**
- **How many people are living with you?**
- **If you are worried about something, who do you talk to?**
- **Are you able to buy enough food?**
- **Are you able to pay your rent?**
- **Are you able to pay your other bills?**
- **How do you feel about this pregnancy?**

### REFERRALS:
- **WIC**
- **Date enrolled**
- **Appointment Date**
- **Car Seat Class**
- **Date Attended**

### MATERIALS GIVEN:
- **Family Planning**
- **Infant Feeding**
- **Other**

### ASSESSMENT SUMMARY:

<table>
<thead>
<tr>
<th>Reviewed By:</th>
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<th>Prenatal Care Provider:</th>
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</table>

IEHP Member Number: 

IEHP Provider Number: 

Next Assessment Date:
**INLAND EMPIRE HEALTH PLAN**

**COMBINED POST-PARTUM ASSESSMENT**

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
<th>Delivery Date</th>
<th>Date</th>
</tr>
</thead>
</table>

**ANTHROPOMETRIC**
- Weight this Visit
- Desirable Body Weight

**BIOCHEMICAL**
- Hemoglobin: H L
- Hematocrit: H L
- Glucose: H L
- Albumin: H L
- Blood Pressure: / (circle) GDM PIH

**CLINICAL - Outcome of Pregnancy**
- Date of Birth
- Gestational Age
- Birth Weight
- Birth Length
- Delivery: □ Vaginal
- □ C-section

**Pregnancy Outcome/Complications:**
- Have you had your post-partum check up?
- □ Y □ N
- If NO, when is it scheduled?
- Have you had any problems since delivery?
- □ Y □ N
- If YES, please explain.

**Maternal**
- Has your baby seen the doctor?
- □ Y □ N
- If NO, when is a visit scheduled?

**NUTRITION**
- 24 hour recall completed
- Are you on a special diet?
- □ Y □ N
- Are you allergic to any foods, or do you avoid eating any foods?
- □ Y □ N
- If YES, what foods?
- Which of the following do you take:
  - □ Prenatal Vitamins
  - □ Iron Pills
  - □ Other Vitamins/Minerals
  - □ Antacids
  - □ Laxatives
  - □ Other Medications
- How many cups, glasses, or cans of these do you drink daily?
  - Water
  - Milk
  - Juice
  - Coffee
  - Tea
  - Soda
  - Diet Soda
  - Punch/Kool Aid
- How many times a day do you usually eat?
- Which of the following do you have?
  - □ Refrigerator
  - □ Stove/Oven
  - □ Hot Plate

**Infant Feeding**
- How many diapers does your baby wet in a day? ______
- If you are Breastfeeding:
  - a) how many times in 24 hours do you nurse? ______
  - b) how long does your baby nurse each time? ______
  - If you are Bottlefeeding:
  - a) how often does your baby get a bottle? ______
  - b) how much does your baby drink at a feeding? ______
  - c) the one(s) you use: □ Concentrated Formula
  - □ Powdered Formula
  - □ Ready to Drink Formula
  - □ Liquid Formula
  - □ Other
  - d) what else do you give your baby?
    - □ Juice
    - □ Cereal
    - □ Sugar Water
    - □ Baby Food
    - □ Other

**HEALTH EDUCATION**
- Do you have any questions about your baby’s care? □ Y □ N
- If YES, please explain.
- Which method of Birth Control are you currently using:
  - □ Birth Control Pills
  - □ Diaphragm
  - □ Condoms
  - □ Norplant
  - □ Depo-Provera(shots)
  - □ Other
- Would you like more information about Birth Control?
- Do you have an infant safety seat?
- □ Y □ N
- If YES, do you always use it?
- Do you exercise 3 or more times a week?
  - □ Y □ N
- Do you smoke?
  - □ Y □ N
- If YES, how many cigarettes per day?
- Do you live with someone who smokes?
- How often do you drink beer, wine, or liquor?
- What drugs have you used since the birth of your baby?

**PSYCHOSOCIAL**
- Since your baby’s birth, which of the following have you had?
  - □ trouble sleeping
  - □ sadness
  - □ worried feelings
  - □ crying
  - □ depression
  - □ sadness
  - □ none
  - □ other
- If YES, by whom?
- Are you and your baby safe in your home?
- Do you need help figuring out how to afford your baby?
- Are you able to buy enough food?
- Are you able to buy enough clothes?
- Are you able to pay your rent?
- Are you able to pay your bills?
- Are you able to keep the heat on?
- Are you able to keep the lights on?
- Are you able to keep the water running?
- Are you able to keep the phone working?
- Are you able to keep the medications coming?
- Are you able to keep the electricity working?
- Are you able to keep the telephone working?
- Are you able to keep the transportation working?
- Are you able to keep the heating working?
- Are you able to keep the transportation running?
- Are you able to keep the heating running?
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22 CA ADC § 51348
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS


(a) Comprehensive perinatal services, as defined in Section 51179, are covered to the extent specified in this section. Prior authorization is required for nutrition, psychosocial and health education services which exceed the Maximum Frequency amounts as set forth in Section 51504.

(b) Except where a capitated health system contract entered into by the Department provides otherwise, obstetrical services in addition to all necessary medical care shall include, but are not limited to:

(1) A written assessment of each patient's obstetrical status.

(2) Preparation of the individualized care plan obstetrical component.

(c) Except where a capitated health system contract entered into by the Department provides otherwise, nutrition services shall include but are not limited to:

(1) Written assessments of each patient's nutritional status.

(A) A complete initial nutrition assessment shall be performed at the initial visit or within four weeks thereafter and shall include: anthropometric data, biochemical data, clinical data, and dietary data.

(B) A nutrition reassessment using updated information shall be offered to each client at least once every trimester and the individualized care plan revised accordingly.

(2) Preparation of the individualized care plan nutritional component that addresses:

(A) The prevention and/or resolution of nutrition problems.

(B) The support and maintenance of strengths and habits oriented toward optimal nutritional status, and;

(C) The goals to be achieved via nutrition interventions.

(3) Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each client.

(4) Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.

(5) Postpartum reassessment, development of a care plan, and interventions.

(d) Except where a capitated health system contract entered into by the Department provides otherwise, health education services shall include, but are not limited to:

(1) Client orientation including, but not limited to provision of detailed information regarding the services to be provided, what to do in case of an emergency, and;

(2) Written assessments of each patient's health education status.

(A) A complete initial education assessment shall be performed at the initial visit or within four weeks thereafter and shall include an evaluation of: current health practices; past experience with health care delivery systems; prior experience with and knowledge about pregnancy, prenatal care, delivery, postpartum self-care, infant care, and safety; client’s expressed learning needs; formal education and reading level; learning methods most effective for the client; educational needs related to diagnostic...
impressions, problems, and/or risk factors identified by staff; languages spoken and written; mental, emotional, or physical
disabilities that affect learning; mobility/residency; religious/cultural influences that impact upon perinatal health; and client and
family or support person's motivation to participate in the educational plan.

(B) An education reassessment using updated information shall be offered to each client every trimester and the individualized
care plan revised accordingly.

(3) Preparation of the individualized care plan health education component that addresses:

(A) Health education strengths.

(B) The prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk
reduction behaviors which can be ameliorated and/or resolved through education.

(C) The goals to be achieved via health education interventions.

(D) Health education interventions based on the patient's identified needs, interests, and capabilities, and particularly directed
toward assisting the patient to make appropriate, well-informed decisions about her pregnancy, delivery, and parenting, with
referrals, as appropriate.

(4) Postpartum assessment, development of care plan, and interventions.

(e) Except where a capitated health system contract entered into by the Department provides otherwise, psychosocial services shall
include, but are not limited to:

(1) Written assessments of each patient's psychosocial status.

(A) A complete initial assessment of psychosocial functioning shall be performed at the initial visit or within four weeks thereafter
and shall include review of: current status including social support system; personal adjustment to pregnancy; history of previous
pregnancies; patient's goals for herself in this pregnancy; general emotional status and history; wanted or unwanted pregnancy,
acceptance of the pregnancy; substance use and abuse; housing/household; education/employment; and financial/material
resources.

(B) A psychosocial reassessment using updated information shall be offered to each client every trimester, and the individualized
care plan revised accordingly.

(2) Preparation of the individualized care plan psychosocial component that addresses:

(A) The prevention and/or resolution of psychosocial problems.

(B) The support and maintenance of strengths in psychosocial functioning, and;

(C) The goals to be achieved via psychosocial interventions.

(3) Treatment and intervention directed toward helping the patient understand and deal effectively with the biological, emotional,
and social stresses of pregnancy with referrals, as appropriate.

(4) Postpartum reassessment, development of a care plan, and interventions.

(f) Review and revisions of the care plan shall occur during the antenatal, intrapartum, and postpartum periods on a regular basis and
will be based on repeated and ongoing assessments and evaluation of the client's status.

(g) Nutrition, psychosocial, and health education services as defined in Sections 51179.2, 51179.3, and 51179.4 shall be provided by
a comprehensive perinatal practitioner as defined under Section 51179.7.

(h) Each Comprehensive Perinatal Provider shall perform the duties of, or shall have on staff or employ or contract with one or more
comprehensive perinatal practitioners as defined in Section 51179.7, to provide interdisciplinary services.

(i) Each Comprehensive Perinatal Provider shall inform the beneficiary what services will be provided, who will provide these services,
where to obtain the services, when the services will be delivered, and procedures to follow in case of emergency.

(j) The Comprehensive Perinatal Provider shall refer patients, as appropriate, to services not specifically made part of comprehensive
perinatal services, as defined in Section 51179. These services shall include, but are not limited to, those provided by the following
programs: Women, Infants, and Children Supplemental Foods, Child Health and Disability Prevention, Family Planning, Genetic
Disease, and Dental.

(k) The Comprehensive Perinatal Provider shall complete and forward to the Department, upon request, a Perinatal Data Form in a
format prescribed by the Department for each patient served.

Note: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and
14134.5, Welfare and Institutions Code.
1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

4. Editorial correction of subsection (i) (Register 95, No. 45).

This database is current through 4/28/17 Register 2017, No. 17

22 CCR § 51348, 22 CA ADC § 51348

END OF DOCUMENT

CONSENT FOR THE HIV TEST

I am consenting to be tested to see whether I have been infected with the Human Immunodeficiency Virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

THE MEANING OF THE TEST
This test is not a test for AIDS but only for the presence of HIV. Being infected with HIV does not mean that I have AIDS or that I will have AIDS or other related illnesses. Other factors must be reviewed to determine whether I have AIDS.

Most test results are accurate, but sometimes the results are wrong or uncertain. In some cases the test results may indicate that the person is infected with HIV when the person is not (false positive). In other cases the test may fail to detect that a person is infected with HIV when the person really is (false negative). Sometimes, the test cannot tell whether or not a person is infected at all. If I have been recently infected with HIV, it may take some time before a test will show the infection. For these reasons, I may have to repeat the test.

CONFIDENTIALITY
California law limits the disclosure of my HIV test results. Under the law, no one but my doctor and other caregivers are told about the test results unless I give specific written consent to let other people know. In some cases, my doctors may disclose my test results to my spouse, any sexual partner(s) or needle-sharing partner(s), the county health officer, or to a health care worker who has had a substantial exposure to my blood or other potentially infectious material. All information relating to this test is kept in my medical record.

BENEFITS AND RISKS OF THE TEST
The test results can help me make better decisions about my health care and my personal life. The test results can help me and my doctor make decisions concerning medical treatment. If the results are positive, I know that I can infect others and I can act to prevent this. Potential risks of the test include psychological stress while awaiting the results and distress if the results are positive. Some persons have had trouble with jobs, housing, education or insurance when their test results have been made known.

MORE INFORMATION
I understand that before I decide to take this test I should be sure that I have had the chance to ask my doctor any questions I may have about the test, its meaning, its risks and benefits, and any alternative to the test.

By my signature below, I acknowledge that I have read and understood the information in this form, that I have been given all of the information I desire concerning the HIV test, its meaning, expected benefits, possible risks, and any alternatives to the tests, and that I have had my questions answered. Further, I acknowledge that I have given consent for the performance of a test to detect HIV.

Signature: ___________________________ Date: ___________ Time _______________ AM/PM

Patient/Parent/Conservator/Guardian

If signed by other than Patient, indicate relationship *: __________________________________________________________

Signature: ___________________________ Date: ___________ Time _______________ AM/PM

*This consent may be signed by a person other than the patient only under the following circumstances:
1. The patient is under twelve (12) years of age or, as a result of his/her physical condition, is incompetent to consent to the HIV antibody blood test; and
2. The person who consents to the test on the patient’s behalf is lawfully authorized to make health care decisions for the patient, e.g., an attorney-in-fact appointed by the patient under the Durable Power of Attorney for Health Care; the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient’s closest available relative (see chapters 2 and 20); and
3. It is necessary to obtain the patient’s HIV antibody test results in order to render appropriate care to the patient or to practice preventative measures. Health and Safety Code section 121020.

Patient Name: ___________________________ DOB: ___________ Member #: ___________________________

Provider Name: ___________________________
Yo doy consentimiento a ser analizado(a) para ver si he sido infectado(a) con el Virus de Inmunodeficiencia Humana (VIH), el cual es el posible agente causante del Síndrome de Inmunodeficiencia Adquirida (SIDA).

EL SIGNIFICADO DEL ANÁLISIS
Este análisis no es para detectar SIDA sino solo la presencia de VIH. El estar infectado(a) con VIH no significa que tengo SIDA ni que voy a tener SIDA u otras enfermedades relacionadas con este. Se deben revisar otros factores antes de determinar que yo tenga SIDA.

La mayoría de los resultados de los análisis son precisos, pero a veces los resultados son equivocados o inexactos. En algunos casos los resultados del análisis podrían indicar que la persona está infectada con VIH cuando en realidad la persona no lo está (positivo falso). En otros casos el análisis puede fallar al detectar que la persona esté infectada con VIH cuando de hecho la persona lo está (negativo falso). A veces el análisis no puede indicar si la persona está infectada o no. Si yo he sido infectado(a) con VIH, podría tomar algún tiempo antes de que el análisis refleje la infección. Por estos motivos, yo tendría que repetir el análisis.

CONFIDENCIALIDAD
La Ley de California limita la revelación de los resultados de mi análisis de VIH. Bajo la ley, nadie más que mi médico y otros asistentes de cuidado saben sobre los resultados del análisis a no ser que yo dé consentimiento específico por escrito de permitirle saber a otras personas los resultados. En algunos casos, mis médicos pueden revelar los resultados de mi análisis a mi cónyuge, algún(os) compañero(s) sexual(es) o compañero(s) que compartan jeringas, al oficial de salud del condado, ó a un(a) trabajador(a) del cuidado de salud que haya sido expuesto(a) substancialmente a mi sangre u otro material potencialmente infeccioso. Toda información relacionada a este análisis se mantiene en mi historial médico.

BENEFICIOS Y RIESGOS DEL ANÁLISIS
Los resultados del análisis pueden ayudarme a tomar mejores decisiones sobre el cuidado de mi salud y mi vida personal. Los resultados del análisis pueden ayudarnos a mí y a mi médico para tomar decisiones referente al tratamiento médico. Si los resultados son positivos, yo sé que puedo infectar a otros y puedo actuar en prevenir esto.

Riesgos potenciales incluyen estrés psicológico mientras la espera los resultados del análisis, y angustia si los resultados son positivos. Algunas personas han tenido problemas con su trabajo, vivienda, educación o seguro cuando se han dado a conocer los resultados del análisis.

MAYOR INFORMACIÓN
Tengo entendido que antes de decidir tomar este análisis debo asegurarme que he tenido la oportunidad de preguntarle a mi médico todas las preguntas que tenga referente al análisis, su significado, sus riesgos y beneficios, y cualquier alternativa al análisis.

Al firmar al calce, confirme que he leído y entendido la información en este documento, que se me ha brindado toda la información que deseo referente al análisis VIH, su significado, beneficios que se esperan, posibles riesgos y cualquier alternativa a los análisis, y que han respondido a mis preguntas.

Además, confirme que he dado mi consentimiento para que se lleve a cabo el análisis para detectar VIH.

Firma: __________________________ Fecha: ________________________ Hora: _____________________ AM/PM

Paciente/Padre/Madre/Conservador/Tutor(a)

Si es firmado por una persona que no es el(a) paciente, indique parentesco *:

Firma: __________________________ Fecha: ________________________ Hora: _____________________ AM/PM

*Este consentimiento puede ser firmado por una persona que no es el(a) paciente, únicamente en las siguientes circunstancias:

1. El(a) paciente es menor de 12 (doce) años de edad ó como resultado de su condición, es incapaz de dar consentimiento para un análisis sanguíneo de anticuerpos VIH; y

2. La persona que da consentimiento al análisis por parte del(a) paciente está autorizada legalmente a tomar decisiones del cuidado de la salud por parte del(a) paciente, por ej.: un apoderado asignado(a) por el(a) paciente bajo la Carta Poder Durable para el Cuidado de Salud; el padre, la madre, ó tutor de un(a) menor; un(a) conservador(a) debidamente autorizado(a), ó bajo circunstancias adecuadas, el(a) familiar más cercano del(a) paciente que esté disponible (ver los capítulos 2 y 20); y

3. Es necesario obtener los resultados de anticuerpos VIH para poder prestar el cuidado adecuado al(a) paciente ó para poner en práctica medidas preventivas. Código de Salud y Seguridad artículo 121020.
CONTRACEPTIVE INFORMED CHOICE

I have read or have had explained to me the information related to the contraceptive method I have chosen. I am aware that there are many methods of birth control I could choose from and that their effectiveness rates are:

- Birth Control Pill: 95-97%
- Cervical Cap and Cream or Jelly: 82-94%
- Diaphragm and Cream or Jelly: 82-94%
- Depo-Provera Injection: 99%
- Female Condom: 79-95%
- Fertility Awareness: 80-98%
- IUD (Intrauterine Device): 99%
- Male Condom: 88-98%
- Natural Family Planning: 80-98%
- Implanon Implants: 99%
- Spermicides (Foam, Suppositories, Vaginal Film): 79-94%
- Sterilization for Men or Women: 99%
- Nuvaring (Vaginal Ring): 99%
- Ortho Evra (Birth Control Transdermal Patch): 98%

I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the method I have chosen. I agree it is my responsibility to return to the clinic as advised. I have been told about the method dangers signs and know when, where and how to get medical care.

Based on my understanding of the above, I have decided to use _________________.

Contact local Family Care Center between 8:00 AM and 5:00 PM, and local hospital emergency room for holidays and after hours (see reverse for locations).

Signed ______________________
Date ______________________
Witness ______________________
Date ______________________
Clinic ______________________
Phone ______________________
ELECCION EDUCADA DE UN ANTICONCEPTIVO

Yo he leído o me han explicado, la información relacionada con el método anticonceptivo que yo he escogido. Estoy enterada de que existen varios métodos para prevenir el embarazo, de los cuales puedo escoger y de que sus porcentajes de efectividad. Ellos son:

- Pastillas Anticonceptivas 95-97%
- Capuchon Cervical con Crema o Jalea Anticonceptiva 82-94%
- Diafragma con Crema o Jalea Anticonceptiva 82-94%
- Inyección de Depo-Provera 99%
- Condom Femenino 79-95%
- Conocimientos sobre Fertilidad 80-98%
- Dispositivo Intrauterino (Aparato) 99%
- Condom Masculino 88-98%
- Planificación Natural de la Familia 80-98%
- Implantes Implanon 99%
- Espermicidas (Espuma, Supositorios, Film Vaginal) 79-94%
- Esterilización para el Hombre o la Mujer 99%
- Nuvaring (Anillo Anticonceptivo Vaginal) 99%
- Ortho Evra (Parche Anticonceptivo Transdermal) 98%

Yo tuve la oportunidad de hacer preguntas, las cuales fueron contestadas a mi entera satisfacción. Yo creo entender los beneficios y riesgos del método que he escogido. Estoy de acuerdo en que es mi responsabilidad regresar a la clínica como se me ha indicado. Me han informado de las señales que pueden indicar complicaciones con mi método y se cuando, donde y como conseguir ayuda médica.

Basada en la comprensión y entendimiento que tengo de lo mencionado arriba, he decidido usar ___________________________________________.

Llame a su clínica familiar local entre las 8:00 am y 5:00 pm, y antes o después de este horario y en los días festivos a la sala de emergencias de su hospital local (vea el reverso de esta hoja para encontrar las teléfonos de las clínicas).

Firma ____________________________
Fecha ____________________________
Testigo ___________________________
Fecha ____________________________
Clinica ___________________________
Teléfono _________________________

Patient Name: _________________________ DOB: __________ Member #: ___________________
Provider Name: _______________________

Attachment 10 - Contraceptive Informed Choice Form - Spanish
DEVELOPMENTAL CHECKUPS FOR CALIFORNIA’S KIDS

Special Discounts for California Providers!

AGES & STAGES QUESTIONNAIRES®, THIRD EDITION (ASQ-3™)
Jane Squires, Ph.D., and Diane Bricker, Ph.D. • ©2009 • Published by Brookes Publishing Co., Inc.

Accurate, cost-effective, and parent-friendly, the new ASQ-3 screens children from one month to 5½ years for developmental delays. 21 age-specific questionnaires contain items in 5 developmental areas—communication, gross motor, fine motor, problem solving, and personal-social—and overall questions to elicit parental concerns.

ASQ-3 Starter Kit (ASQ-3 User’s Guide, paper masters of 21 questionnaires and scoring sheets, CD-ROM with printable PDF questionnaires, ASQ-3 Quick Start Guide, and carrying box)
ASQ-3 Starter Kit with English Questionnaires: US$249.95 US$199.96 • Stock#: PK0901-70410
ASQ-3 Starter Kit with Spanish Questionnaires: US$249.95 US$199.96 • Stock#: PK0901-70427

Electronic management and online questionnaire completion, plus ASQ:SE for social-emotional screening, also available.

Ordering Information: www.agesandstages.com  Toll-free (800) 638-3775
Please use List Code PK0901 to receive your 20% discount.

PARENTS’ EVALUATION OF DEVELOPMENTAL STATUS (PEDS)
Frances Page Glascoe, Ph.D. • ©2009 • Published by EV Press, LLC

10 questions, same throughout 0 to 8 years, that guide clinicians into evidence-based decisions to address parents’ concerns about developmental and social-emotional needs.

PEDS:DEVELOPMENTAL MILESTONES (PEDS:DM)
Frances Page Glascoe, Ph.D., and Nicholas S. Robertshaw • ©2008 • Published by EV Press, LLC

6 – 8 questions per age level for 0 – 8 years measuring fine and gross motor, receptive and expressive, self-help, social-emotional and academic skills. Supplemental measures include screens for autism, psychosocial risk and academic and mental health skills for older children. The PEDS:DM Assessment Level version is useful for NICU follow-up and EI services.

PEDS Starter Kit in English, Spanish, or Vietnamese: US $30.00 US $22.50
PEDS:DM Starter Kit in English or Spanish: US $275.00 US $247.50
Ordering/Additional Languages and Online Application: www.pedstest.com  Phone: 615-776-4121

CHADIS (CHILD HEALTH & DEVELOPMENT INTERACTIVE SYSTEM)
© 2003-2009 • Published by Total Child Health, Inc.

CHADIS is a web-based screening, diagnostic and management system that administers and analyzes pre-visit, online questionnaires completed by parents, teachers and teens. CHADIS is both a questionnaire-delivery and decision-support system, with clinical resources, management information and an e-textbook improving the diagnosis and supervision of health, emotional and behavioral issues, while streamlining other routines of Pediatric care.

Currently CHADIS automatically delivers, scores, tabulates and supports over 25 screening tools that respondents complete anywhere Internet access is available, including ASQ-3™, M-CHAT, Vanderbilt Parent and Teacher, Pediatric System Checklist, PEDS© and ProPHDS©.

Please mention code CA HEALTH for 20% off CHADIS’s standard rate card!

For Ordering: www.CHADIS.com  Toll-free (888) 4-CHADIS  info@CHADIS.com

WHY USE CHADIS?
Increase Practice Success!

• Provide Better Coordinated Care
• Improve Office Flow & Cost Structure
• Measure & Track Quality of Care
• Augment QI initiatives
• Support & document billing for 96110
HIV TESTING SITES
RIVERSIDE COUNTY

BANNING FAMILY CARE CENTER
3055 W. Ramsey, Banning
Appointments: (800) 720-9553

CORONA FAMILY CARE CENTER
505 S. Buena Vista Ave, Ste 101, Corona
Appointments: (800) 720-9553

DESERT AIDS PROJECT (DAP)
1695 N Sunrise Way, Palm Springs
Appointments: (866) 331-3344
Testing Times: Mon & Thur (4:30-6:30 pm)

DESERT AIDS PROJECT – INDIO
81-893 Dr. Carreon Blvd, Ste 3, Indio
Appointments: (866) 331-3344
Testing Times: 1st & 3rd Wed (4:00-7:00 pm)

HEMET FAMILY CARE CENTER
880 N. State Street, Hemet
Appointments: (800) 720-9553

INDIO FAMILY CARE CENTER
47-923 Oasis St, Indio
Appointments: (800) 720-9553

JURUPA FAMILY CARE CENTER
9415 Mission Blvd, Riverside
Appointments: (800) 720-9553

LAKE ELSINORE FAMILY CARE CENTER
2499 E. Lakeshore Dr, Lake Elsinore
Appointments: (800) 720-9553

PALM SPRINGS FAMILY CARE CENTER
1515 North Sunrise Way, Palm Springs
Appointments: (800) 720-9553

PERRIS FAMILY CARE CENTER
Don Robert Bruce Reid Health Clinic
308 E. San Jacinto Ave, Perris
Appointments: (800) 720-9553

RIVERSIDE NEIGHBORHOOD HEALTH CENTER
7140 Indiana Ave, Riverside
Appointments: (800) 720-9553

RUBIDOUX FAMILY CARE CENTER
Don Schroeder Family Care Center
5256 Mission Blvd, Riverside
Appointments: (800) 720-9553

WORKING WONDERS
32140 Shifting Sands, Bldg 1, Cathedral City
(760) 324-7586
Testing Times:
Every Other Tuesday (2:00-4:00 pm)

FOR FURTHER INFORMATION CALL: 1-800-243-7275
SAN BERNARDINO COUNTY
DEPARTMENT OF PUBLIC HEALTH
HIV/AIDS CLINIC
799 E. Rialto Ave., San Bernardino
Appointments: (800) 722-4777
Testing Times: Mon, Wed, Fri (8:30-4:30 pm)

SAN BERNARDINO COUNTY
DEPARTMENT OF PUBLIC HEALTH
HIV/AIDS CLINIC
1647 Holt Ave., Ontario
Appointments: (800) 722-4777
Testing Times: Mon - Fri (8:00-5:00 pm)

SAN BERNARDINO COUNTY
DEPARTMENT OF PUBLIC HEALTH
HIV/AIDS CLINIC
16453 Bear Valley Rd., Hesperia
Appointments: (800) 722-4777
Testing Times: Mon - Fri (8:00-5:00 pm)

AIDS HEALTHCARE
8263 Grove Ave., Ste 201, Rancho Cucamonga
(909) 579-0708
Testing Times: Tue (8:30-8:00 pm) / Thu (8:30-5:30 pm)

H STREET CLINIC (Desert AIDS Project)
1329 North H Street, San Bernardino
Appointments: (909) 381-0803

CDC NATIONAL AIDS HOTLINE
(800) 342-2437 or (800) 232-4636
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Yes</th>
<th>No</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What languages do you speak?</td>
<td>□ English □ Spanish Other</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. What languages do you read?</td>
<td>□ English □ Spanish Other</td>
<td></td>
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<tr>
<td>3. How many years of school have you finished?</td>
<td></td>
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<tr>
<td>4. Do you have a job?</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
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<tr>
<td>5. Does your partner have a job?</td>
<td>□ Yes □ No</td>
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<tr>
<td>6. Are you on a special diet?</td>
<td>□ Yes □ No</td>
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<tr>
<td>7. Are you a vegetarian?</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. Are you allergic to any foods, or do you try not to eat any foods?</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. How many cups, glasses or cans of these do you drink every day?</td>
<td></td>
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</tr>
<tr>
<td>10. How many times a day do you usually eat (including snacks)?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11. Do you have nausea</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. What home remedies, food supplements, or herbs are you taking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. During this pregnancy, have you eaten</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. During this pregnancy, are you taking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td>□ L □ M □ H</td>
<td></td>
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</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15. How do you plan to feed your new baby?</td>
<td>☐ Breast ☐ Bottle ☐ Both ☐ not sure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Have you breastfed a baby before?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. a. Where are you living right now?</td>
<td>☐ House ☐ Apartment ☐ Motel</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. How long have you lived there?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. How many people live with you?</td>
<td>☐ no one ☐ 1-3 others ☐ 4-6 others ☐ 7 or more others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. If you are worried about something, who do you talk to?</td>
<td>☐ partner/husband ☐ parents ☐ grandparents ☐ other relatives ☐ friend ☐ other person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Do you have (☐ if yes)</td>
<td>☐ electricity ☐ hot water ☐ refrigerator ☐ stove or oven</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Are you usually able to (☐ if yes)</td>
<td>☐ buy enough food ☐ pay rent ☐ pay other bills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever had trouble finding a doctor, or getting medical help for yourself or your family?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Are you on the WIC (Women, Infants &amp; Children) Program?</td>
<td>☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>24. Do you have an infant car seat?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
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<tr>
<td>25. Do you use your car seat belt?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26. Was your pregnancy planned?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. How does the baby’s father feel about this pregnancy?</td>
<td>☐ doesn’t care ☐ doesn’t know ☐ angry ☐ happy ☐ sad ☐ other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. How do you feel about this pregnancy?</td>
<td>☐ don’t care ☐ angry ☐ happy ☐ sad ☐ other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Have you ever had any of the following?</td>
<td>☐ Miscarriage ☐ abortion ☐ stillbirth ☐ fetal demise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ neonatal death ☐ premature birth ☐ none</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Do you have any traditional, cultural, or religious customs about pregnancy or childbirth you would like supported?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Since becoming pregnant, which of the following have you had? (☐ if yes)</td>
<td>☐ problem sleeping ☐ excessive worrying ☐ crying ☐ depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ sadness ☐ none ☐ other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Are you taking medicine for your nerves?</td>
<td>☐ Yes ☐ No Name of Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. What two problems in your life cause you the most trouble?</td>
<td>☐ ☐</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>34. Have you ever thought about, planned, or tried to hurt yourself?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Have you ever thought about, planned, or tried to hurt someone else?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. In the past year, have you been slapped, hit, kicked, or otherwise physically hurt someone?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By whom? (Check all that apply)</td>
<td>☐ partner/husband ☐ ex-husband ☐ parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ step-parent ☐ stranger ☐ brother/sister ☐ other</td>
<td>☐ # times hurt</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
37. On this picture mark the area of the body where you have been hurt.

38. For how many months or years have you been hurt by this person?

39. How many cigarettes do you smoke each day?

40. Do you live with anyone who smokes?

41. Check all that apply:
   a. Does the father of your baby use drugs or drink alcohol?  
      Yes  No
   b. What drugs did you use before this pregnancy?
      Yes  No
   c. How often do you drink beer, wine, or liquor?
      Yes  No

42. Have you received counseling on HIV (AIDS) in pregnancy?

43. Tell us what you know about and want to learn about:
   Already    Like to
   Know    Know
   Child Care    Breastfeeding
   Hospital Tour    Infant Feeding
   Labor & Delivery    Baby Care
   Sexual Abuse    Exercise
   Circumcision    Stop Smoking
   Substance Abuse    Domestic Violence
   How Your Baby Grows    Sexually Transmitted Disease
   Making Children Behave    Body Changes During Pregnancy
   Car Seat Safety    Other
   Signs of Preterm Labor

44. a. How do you learn new things best? (Please check all that apply)
   b. Do you have any problems with hearing, seeing, or depression that will make it hard for you to learn new things?  
   c. How often do you drink beer, wine, or liquor?

45. a. Will you have any problems coming to prenatal classes?  
   b. Who can come to prenatal classes with you?
   c. List one or two things (goals) you would like to work on during this pregnancy.

If patient assisted by staff to complete assessment tool
Assessment Tool Completed by:
INITIAL PERINATAL RISK ASSESSMENT

Name______________________________  Title________________________________  Date__________________________

Assessment Reviewed by:

Name (OB)__________________________  Title________________________________  Date__________________________
Name (H.E.)__________________________  Title________________________________  Date__________________________
Name (Nut.)__________________________  Title________________________________  Date__________________________
Name (Psych. Soc.)__________________________  Title________________________________  Date__________________________

2nd Trimester reassessment completed by:

Name (OB)__________________________  Title________________________________  Date__________________________
Name (H.E.)__________________________  Title________________________________  Date__________________________
Name (Nut.)__________________________  Title________________________________  Date__________________________
Name (Psych. Soc.)__________________________  Title________________________________  Date__________________________

3rd Trimester assessment completed by:

Name (OB)__________________________  Title________________________________  Date__________________________
Name (H.E.)__________________________  Title________________________________  Date__________________________
Name (Nut.)__________________________  Title________________________________  Date__________________________
Name (Psych. Soc.)__________________________  Title________________________________  Date__________________________

Postpartum assessment completed by:

Name (OB)__________________________  Title________________________________  Date__________________________
Name (H.E.)__________________________  Title________________________________  Date__________________________
Name (Nut.)__________________________  Title________________________________  Date__________________________
Name (Psych. Soc.)__________________________  Title________________________________  Date__________________________

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Riverside/San Bernardino County DOPH-CPSP Program
FECHA: ____________  NOMBRE: ________________________________________

EDAD: ____________  CUANDO va DAR a LUZ: ____________  NUMERO de IDENTIFICACION: _________________________

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)
(Note: Complete Diet Recall and weight gain grid at this time if not already completed.)

Favor de responder las siguientes preguntas marcando con una √ en el ☐ o escribiendo en los espacios en blanco.

1. ¿Qué idiomas habla usted? ☐ inglés ☐ español ☐ otros _____________

2. ¿Cuántos años de escuela ha completado? ___________ años ☐ ingles ☐ español ☐ otros _____________

3. ¿Está usted llevando una dieta especial? ☐ para bajar de peso ☐ baja en grasa/colesterol ☐ baja en sal ☐ para diabéticos ☐ otra _____________

4. ¿Tiene trabajo su pareja? ☐ sí ☐ no  ¿Qué tipo de trabajo? _____________

5. ¿Tiene trabajo su pareja? ☐ sí ☐ no  ¿Qué tipo de trabajo? _____________

6. ¿Está usted vegetariana? ☐ sí ☐ no  ¿Cuántas tazas, vasos o latas de los siguientes líquidos bebe usted diariamente? _______

   agua ___________ leche ___________ jugo ___________ soda de dieta ___________

   refresco/"kool aid" ___________ café ___________ té ___________ otra ___________

7. ¿Es usted vegetariana? ☐ si ☐ no  Si contestó “sí”, ¿consume usted productos lácteos (queso, leche, yogurt) y/o huevos? ☐ si ☐ no

8. ¿Es usted alérgica a algún alimento o existe algún alimento que evite comer? ☐ sí ☐ no  Si contestó “sí”, ¿cuáles son esos alimentos? _____________

9. ¿Cuántas tazas, vasos o latas de los siguientes líquidos bebe usted diariamente? _______

   agua ___________ leche ___________ jugo ___________ soda de dieta ___________

   refresco/"kool aid" ___________ café ___________ té ___________ otra ___________

10. ¿Cuántas veces al día come usted generalmente (incluyendo bocadillos)? __________

11. ¿Quién ha comido usted lo siguiente?

   náusea ☐ sí ☐ no  ¿Con qué frecuencia? __________

   vómito ☐ sí ☐ no  ¿Con qué frecuencia? __________

   mal apetito ☐ sí ☐ no  ¿Con qué frecuencia? __________

   pérdida de peso ☐ sí ☐ no  ¿Con qué frecuencia? __________

   diarrea ☐ sí ☐ no  ¿Con qué frecuencia? __________

   estreñimiento ☐ sí ☐ no  ¿Con qué frecuencia? __________

   acidez estomacal ☐ sí ☐ no  ¿Con qué frecuencia? __________

   otra __________

12. ¿Qué remedios caseros, suplementos alimenticios y hierbas está usted tomando? __________

   Ginseng/ ginsén ☐ si ☐ no  ¿Con qué frecuencia? __________

   Ma Huang/ belcho (ephedra) ☐ si ☐ no  ¿Con qué frecuencia? __________

   Hierbabuena (mint) ☐ si ☐ no  ¿Con qué frecuencia? __________

   Hierbabuena (mint) ☐ si ☐ no  ¿Con qué frecuencia? __________

   otra __________

13. ¿Durante este embarazo, ¿ha comido usted lo siguiente? __________

   maicena (cornstarch) ☐ si ☐ no  ¿Con qué frecuencia? __________

   almíndon (cornstarch) ☐ si ☐ no  ¿Con qué frecuencia? __________

   tierra o barro ☐ si ☐ no  ¿Con qué frecuencia? __________

   engrado o yeso ☐ si ☐ no  ¿Con qué frecuencia? __________

   escarcha del congelador ☐ si ☐ no  ¿Con qué frecuencia? __________

   otra __________

14. ¿Durante este embarazo, ¿está usted tomando lo siguiente? __________

   aspirina ☐ si ☐ no  ¿Con qué frecuencia? __________

   medicinas para resfriados/ catarros ☐ si ☐ no  ¿Con qué frecuencia? __________

   medicinas para alergias/ sinusitis ☐ si ☐ no  ¿Con qué frecuencia? __________

   pastillas de dieta ☐ si ☐ no  ¿Con qué frecuencia? __________

   vitaminas prenatales ☐ si ☐ no  ¿Con qué frecuencia? __________

   otras vitaminas ☐ si ☐ no  ¿Con qué frecuencia? __________

   pastillas de hierro ☐ si ☐ no  ¿Con qué frecuencia? __________

   otra __________
INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT
PROVIDER INFORMATION:

Provider Name: ____________________________  IEHP Provider Number: ____________________________

15. ¿Cómo planea usted alimentar a su nuevo bebé?  
   □ pecho  □ biberón  □ ambos  
   □ no estoy segura

16. ¿Ha amamantado usted antes a un bebé?  
   □ sí  □ no  
   Si contestó “sí”, ¿por cuánto tiempo amamantó? ____________________

17. a. ¿Dónde está usted viviendo ahora?  
    □ casa  □ departamento  □ motel  
    □ en la casa o departamento de un amigo(a)  □ carro  □ calle  □ otro

b. ¿Por cuánto tiempo ha vivido allí? ____________________

18. ¿Cuántas personas viven con usted?  
   □ nadie  □ 1-3 personas  □ 4-6 personas  □ 7 o más personas

19. Cuando le preocupa algo, ¿con quién habla usted?  
   □ esposo/pareja  □ padres  □ abuelos  □ otros familiares  
   □ amiga(o)  □ otra persona

20. ¿Tiene usted lo siguiente? (Indique con una √ en el □ si su respuesta es “sí”)  
   □ electricidad  □ agua caliente  □ refrigerador  □ estufa u horno  
   □ transporte  □ teléfono  □ calefacción

21. Generalmente, ¿puede usted hacer lo siguiente? (Indique con una √ en el □ si su respuesta es “sí”)  
   □ H  
   □ comprar suficiente comida  □ pagar el alquiler  □ pagar otras cuentas

22. ¿Ha tenido usted alguna vez problemas buscando un doctor o consiguiendo ayuda médica para usted o su familia?  
   □ sí  □ no  
   Si contestó “sí”, favor de explicar:

23. ¿Está usted inscrita en el programa WIC (programa para mujeres, infantes y niños)?  
   □ sí  □ no

24. ¿Tiene usted un asiento de seguridad para su bebé?  
   □ sí  □ no

25. ¿Usa usted los cinturones de seguridad de su carro?  
   □ sí  □ no

26. ¿Fue este embarazo planeado?  
   □ sí  □ no

27. ¿Cómo se siente el padre del bebé sobre este embarazo?  
   □ feliz  □ triste  □ otro

28. ¿Cómo se siente usted sobre este embarazo?  
   □ feliz  □ triste  □ otro

29. ¿Ha tenido usted alguna vez lo siguiente?  
   □ aborto natural (malparto)  □ aborto provocado  □ parto de un feto muerto  
   □ muerte fetal  □ muerte neonatal (de un recién nacido)  □ bebé prematuro  
   □ otra

   ¿Cuándo sucedió? ____________________

30. ¿Qué/quién la ayudó a afrontar esta situación?  
    □ una persona  □ otra persona  □ otros

31. Desde que usted se embarazó, ¿ha estado teniendo o sintiendo lo siguiente?  
   (Indique con una √ en el □ si su respuesta es “sí”)  
   □ problemas para dormir  □ demasiada preocupación  □ llorando  □ depresión  
   □ tristeza  □ ninguna  □ otra

32. ¿Está usted tomando medicina para los nervios?  
   □ sí  □ no  Nombre de la medicina: ____________________

33. ¿Cuáles son los dos problemas en su vida que más le preocupan?  
    □ 1. ____________________  □ 2. ____________________

34. ¿Ha pensado, planeado o tratado usted alguna vez de hacerse daño?  
   □ sí  □ no

35. ¿Ha pensado, planeado o tratado usted alguna vez de hacerle daño a alguien más?  
   □ sí  □ no

36. Durante el transcurso del último año, ¿ha sido usted abofeteada, golpeada, pateada o lastimada físicamente por alguien?  
   □ sí  □ no

   ¿Por quién? (Marque todas las respuestas que correspondan)  
   □ esposo/pareja  □ ex-esposo  □ padre/madre  □ padrastro/madrastra  
   □ hermano(a)  □ desconocido  □ otro

   # de veces que ha sido lastimada ____________________
37. Indique en este dibujo el área del cuerpo donde usted ha sido lastimada:
   - [ ] no fumo
   - [ ] menos de 1/2 cajetilla
   - [ ] 1/2 cajetilla
   - [ ] 1-2 cajetillas
   - [ ] 2-3 cajetillas
   - [ ] más de 3 cajetillas

38. ¿Por cuántos meses o años la ha lastimado a usted esta persona? ___________________

39. ¿Cuántos cigarrillos fuma usted por día?
   - [ ] no fumo
   - [ ] menos de 1/2 cajetilla
   - [ ] 1/2 cajetilla
   - [ ] 1-2 cajetillas
   - [ ] 2-3 cajetillas
   - [ ] más de 3 cajetillas

40. ¿Vive usted con alguien que fuma?
   - [ ] sí
   - [ ] no

41. Marque todas las respuestas que correspondan:
   a. ¿Usa el padre de su bebé drogas o bebidas alcohólicas?
      - [ ] sí
      - [ ] no

   b. ¿Cuáles drogas usó usted antes de este embarazo?
      - [ ] cocaína
      - [ ] marihuana
      - [ ] metanfetaminas (speed)
      - [ ] PCP
      - [ ] heroína
      - [ ] ninguna
      - [ ] otra _______________

   c. ¿Con qué frecuencia toma usted cerveza, vino, o licor?
      - [ ] diariamente
      - [ ] fines de semana
      - [ ] 1-2 veces por mes
      - [ ] raramente o nunca

   - Desde que usted quedó embarazada ¿han cambiado sus hábitos de tomar bebidas alcohólicas?
      - [ ] sí
      - [ ] no

   - Si contestó “sí”, explique: _______________________________________________________

42. ¿Ha recibido usted consejería sobre el VIH (SIDA) con el embarazo?
   - [ ] sí
   - [ ] no

43. Díganos sobre que temas usted ya sabe y sobre cuales le gustaría saber:
   - Me gustaría saber
   - Ya sé saber
   - [ ] El cuidado de un niño
   - [ ] Recorrido del hospital
   - [ ] El parto
   - [ ] Abuso sexual
   - [ ] Circuncisión
   - [ ] Abuso de substancias
   - [ ] El crecimiento de un bebé
   - [ ] Guiando al niño en su comportamiento
   - [ ] Asiento de seguridad
   - [ ] Señales de un parto prematuro

   - Me gustaría
   - Ya sé saber
   - [ ] Amamantando a un bebé
   - [ ] Alimentación infantil
   - [ ] El cuidado de un bebé
   - [ ] Ejercicio
   - [ ] Dejando de fumar
   - [ ] Violencia en el hogar
   - [ ] Enfermedades transmitidas sexualmente
   - [ ] Cambios del cuerpo durante el embarazo

44. a. ¿De qué manera aprende usted mejor algo nuevo? (Marque todas las respuestas que correspondan)
   - [ ] leyendo
   - [ ] mirando un video
   - [ ] hablando cara a cara
   - [ ] yendo a clase
   - [ ] dibujos o diagramas
   - [ ] demostración
   - [ ] otra ______________

   b. ¿Tiene usted algún problema de depresión, para oír, o para ver lo cual dificultaría el que pueda aprender cosas nuevas?
      - [ ] sí
      - [ ] no

   - Si contestó “sí”, favor de explicar: ________________________________________________

45. a. ¿Va a tener usted algún problema para venir a las clases prenatales?
   - [ ] sí
   - [ ] no

   - Si contestó “sí”, favor de explicar: ________________________________________________

46. Escriba una o dos cosas (metas) sobre las que quisiera enfocarse durante este embarazo?
   1. _____________________________________________________________________________
   2. _____________________________________________________________________________

If patient assisted by staff to complete assessment tool
## Initial Perinatal Risk Assessment Form - Spanish

### Assessment Tool Completed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

### Assessment Reviewed by:

<table>
<thead>
<tr>
<th>Name (OB)</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (HE)</td>
<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Nut.)</td>
<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Psych. Soc.)</td>
<td>Title</td>
<td>Date</td>
</tr>
</tbody>
</table>

### 2nd Trimester reassessment completed by:

<table>
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</tr>
</thead>
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<tr>
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<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Nut.)</td>
<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Psych. Soc.)</td>
<td>Title</td>
<td>Date</td>
</tr>
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### 3rd Trimester assessment completed by:

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<th>Title</th>
<th>Date</th>
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<tr>
<td>Name (HE)</td>
<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Nut.)</td>
<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Psych. Soc.)</td>
<td>Title</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Postpartum assessment completed by:

<table>
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<tr>
<th>Name (OB)</th>
<th>Title</th>
<th>Date</th>
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<tbody>
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<td>Title</td>
<td>Date</td>
</tr>
<tr>
<td>Name (Psych. Soc.)</td>
<td>Title</td>
<td>Date</td>
</tr>
</tbody>
</table>

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Riverside/San Bernardino County DOPH-CPSP Program*
HEALTH AND SAFETY CODE
SECTION 1367.62

1367.62. (a) No health care service plan contract that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The contract covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.

(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the health care service plan prior to prescribing any services covered by this section.

(b) (1) Every health care service plan shall include notice of the coverage specified in subdivision (a) in the plan's evidence of coverage for evidences of coverage issued on or after January 1, 1998, and except as specified in paragraph (2), shall provide
additional written notice of this coverage during the course of the enrollee's prenatal care. The contract may require the treating physician or the enrollee's medical group to provide this additional written notice of coverage during the course of the enrollee's prenatal care.

(2) Health care service plans that issue contracts that provide for coverage of the type commonly referred to as "preferred provider organizations" shall provide additional written notice to all females between the ages of 10 and 50 who are covered by those contracts of the coverage under subdivision (a) within 60 days of the effective date of this act. The plan shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The plan previously notified subscribers that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

(c) Nothing in this section shall be construed to prohibit a plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.
### Table 21.4 CHDP/EPSDT PERIODICITY SCHEDULE FOR DENTAL REFERRAL BY AGE

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Routine Dental Referral</th>
<th>Suspected Dental Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1* - 20</td>
<td><strong>Refer every 6 months</strong> (Children with special needs may need more frequent referrals)</td>
<td>Refer at any age if a problem is suspected or detected</td>
</tr>
</tbody>
</table>

- A dental screening/oral assessment is required at every CHDP/EPSDT*** health assessment regardless of age.
- Refer children directly to a dentist:
  - **Beginning at age one** as required by California Health and Safety Code Section 124040 (6)(D) [http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hs&group=124001-125000&file=124025-124110](http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hs&group=124001-125000&file=124025-124110)
  - **At any age** if a problem is suspected or detected – See CHDP Dental Referral Classifications [http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/pm160dentalguide.pdf](http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/pm160dentalguide.pdf)
  - **Every three (3) months** for children with documented special health care needs when medical or oral condition can be affected; and for other children at high risk for dental caries.
- To help find a dentist:
  - For a child with Medi-Cal, contact Denti-Cal at 1-800-322-6384 or [http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral](http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral)
  - For families with or without Medi-Cal, the local CHDP program can assist in finding a dentist. [http://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx](http://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx)

* The American Academy of Pediatrics (AAP) policy is to establish a dental home by age one: [http://pediatrics.aappublications.org/content/134/6/1224.full.pdf+html](http://pediatrics.aappublications.org/content/134/6/1224.full.pdf+html)

For Medi-Cal eligible children, Denti-Cal will cover preventive services (exam, topical fluoride application, and prophylaxis) once in a six month period and more frequently if there is a documented necessity. Denti-Cal has adopted the American Academy of Pediatric Dentistry’s (AAPD) “Recommendations for Preventive Pediatric Oral Health Care” which indicates frequencies for diagnostic and preventive procedures: [http://www.denti-cal.ca.gov/provsnrcs/bulletins/Volume_26_Number_7.pdf](http://www.denti-cal.ca.gov/provsnrcs/bulletins/Volume_26_Number_7.pdf). The AAPD emphasizes the importance of very early professional intervention and continuity of care beginning with the eruption of the first tooth and no later than 12 months of age: [http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf)

*** Child Health and Disability Prevention (CHDP) Program/Early Periodic Screening Diagnosis and Treatment (EPSDT)
CONSENT FORM  
PM 330

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from ______________________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________________________.

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the witholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ______________ / __________ / ________.

I ____________________________________________________________.

In the __________________________ (Name of individual to be sterilized) hereby consent of my own free will to be sterilized by ______________________________ (Name of procedure) method called ______________________________ (doctor’s name) for the purpose of ______________________________ (Name of procedure). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services.
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

__________________________________________________________ Date: / / 
Signature of individual to be sterilized  Mo Day Yr

INTERPRETER’S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________________________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

__________________________________________________________ Date: / / 
Signature of Interpreter  Mo Day Yr

STATEMENT OF PERSON OBTAINING CONSENT

Before ______________________________ signed the consent form, I explained to him/her the nature of the sterilization operation ______________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent  Date: / / 
Mo Day Yr

Name of Facility where patient was counseled

Address of Facility where patient was counseled  City State Zip Code

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon ______________________________ (Name of individual to be sterilized) on ______________ / __________ / ________.

I explained to him/her the nature of the sterilization operation ______________________________, the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form because of the following circumstances. Cross out the paragraph below which is not used.

(1) At least thirty days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances. (Check applicable box below and fill in information requested.)

A  Box    Premature delivery date: ______________ / __________ / ________ Individual’s expected date of delivery: ______________ / __________ / ________ (Must be 30 days from date of patient’s signature).

B  Box    Emergency abdominal surgery; describe circumstances: ______________________________

Signature of Physician performing surgery  Date: / / 
Mo Day Yr
■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de ___________________________. Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA PERMANENTE E IRREVERSIBLE. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirán en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos métodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como: ___________________________.

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicos ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ___________________________.

Nombre: ___________________________ Día: ___________________________ Año: ___________________________

Apellido: ___________________________ Día: ___________________________ Año: ___________________________

Dirección del lugar donde el paciente recibió la información: ____________________________________________

Ciudad: ___________________________ Estado: ___________________________ Código Postal: ___________________________

■ DECLARACIÓN DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que ___________________________ firme el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como ___________________________.

También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

■ DECLARACIÓN DEL MÉDICO ■

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma ___________________________ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

Firma del intérprete: ___________________________ Mes: ___________________________ Día: ___________________________ Año: ___________________________
**PERINATAL PROGRAM**

**Pregnancy Notification Form /Outcome Report**

**DIRECTIONS FOR COMPLETION:**

A. **Pregnancy Notification Report:** complete and mail with HCFA 1500 Form within 14 days of the initial prenatal visit. This visit should include, but not be limited to, medical history, physical, cervical cytology screening, chlamydia cultures and other appropriate prenatal labs.

B. **Pregnancy Outcome Report:** complete and mail with HCFA 1500 Form within 14 days of post-partum visit.

**Please send report(s) to:**
Inland Empire Health Plan
CLAIMS
PO Box 4349
Rancho Cucamonga, CA 91729-4349

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**A. PREGNANCY NOTIFICATION REPORT (to be completed at initial prenatal visit)**

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<td>Chlamydia</td>
<td>Initial Risk Assessment</td>
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**HIGH RISK CONDITIONS**

- Maternal age _____ <17 or >34
- Diabetes o Type
- Multiple Pregnancy
- HTN o
- Thyroid Disease o
- Smoker o
- Packs a day? _______
- Cardiac Disease
- Drug Abuse o
- ETOH Abuse o
- Other o

**PREVIOUS PREGNANCY HISTORY**

- History of Pre-term labor o
- History of low birth weight o
- Other o
- History of fetal demise, stillborn or neonatal death o
- History of pre-eclampsia/toxemia o

**B. PREGNANCY OUTCOME REPORT (to be completed after delivery)**

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<th>Delivery date</th>
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<td>Birth Weight</td>
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**TYPE OF DELIVERY**

- Vaginal o
- C-Section o
- VBAC o
- Repeat C-Section o
- C-Section for failed o
- VBAC o
- Maternal death Yes o No o
- Fetal death Yes o No o
Prenatal Diagnosis Centers and Satellite Locations
State-approved for Expanded AFP Follow-up

RIVERSIDE COUNTY:

Integrated Genetics - Monrovia
(760) 323-6436 Wed(AM), Thu

Prenatal Diagnostic &
Perinatal Center - Corona
(951) 279-6666 Wed(AM)

Prenatal Diagnostic &
Perinatal Center - Indio
(760) 775-5373 – Tue (AM)

Prenatal Diagnostic and
Perinatal Center – Hemet
(951) 652-2811 Friday

Genzyme Genetics –
Temecula ValPerinat, Murrieta
(858) 939-6860 Tue and Fri

Prenatal Diagnostic &
Perinatal Center - Riverside
(951) 683-4675 Tue(AM), Thu

Prenatal Diagnostic &
Perinatal Center - Wildomar
(951) 304-3335 Wed (AM)

Kaiser Permanente, SoCal -
Riverside
(951) 353-3494 Mon – Fri

Genzyme Pasadena
Palm Springs
(760) 323-6436 Tues. & Wed.

SAN BERNARDINO COUNTY:

Genesis Labs - Loma Linda
(909) 651-5976 Mon - Fri

Prenatal Diagnostic &
Perinatal Center - A.Valley
(760) 242-1677 Mon (AM)

Prenatal Diagnostic &
Perinatal Center - Indio
(909) 482-1777 Thur(AM)

San Gabriel Valley Perinatal
Medical Group – Chino Hills
(909) 865-9705 Tue

Prenatal Diagnostic &
Perinatal Center - S.B
(909) 883-9222 Mon(PM), Wed(PM)

Prenatal Diagnostic &
Perinatal Center - Colton
(909) 580-3347 Thur and
2nd Friday of every month

Kaiser Permanente - Fontana
(909) 427-4381 Mon - Fri

Kaiser Permanente - Ontario
(909) 427-3089 Mon, Wed, Thur

STATE PROGRAM INFO:
For the most current listing of State-approved Prenatal Diagnosis Centers by County, go to
http://www.cdph.ca.gov or call the Genetic Disease Branch, California Department of Health Care
Services at 1 (866) 366-4408.
### Recommendations for Preventive Pediatric Health Care

**Bright Futures/American Academy of Pediatrics**

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Hagan JF, Shaw JC, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2017 by the American Academy of Pediatrics, updated February 2017. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.

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#### Table: Age-Specific Recommendations

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</tbody>
</table>

**KEY:**
- ✔ = to be performed
- □ = risk assessment to be performed with appropriate action to follow, if positive
- ○ = range during which a service may be provided

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1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a continuation. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of the benefits of breastfeeding and planned method of feeding, per “The Prenatal Visit” (http://pediatrics.aappublications.org/content/124/4/1278).

3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction as recommended in “Breastfeeding and the Use of Human Milk” (http://pediatrics.aappublications.org/content/125/5/827.full). Newborns discharged less than 48 hours after delivery need a feeding and nutrition evaluation (NAF). If the NAFF is performed, verify results, and follow up, as appropriate. Newborns should be screened, per “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” (http://pediatrics.aappublications.org/content/118/1/248.full).

5. Screen, per “Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report” (http://pediatrics.aappublications.org/content/120/Supplement_A/454.full).

6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess vision at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/113.full) and “Precautions for the Evaluation of the Visual System by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/1055.full).

8. Confirm initial screen was completed, verified results, and follow up, as appropriate. Newborns should be screened, per “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” (http://pediatrics.aappublications.org/content/118/1/248.full).

9. Verify results as soon as possible, and follow up, if appropriate.

10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See “The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies” (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).


12. Screening should occur per “Identification and Evaluation of Children With Autism Spectrum Disorders” (http://pediatrics.aappublications.org/content/125/5/827.full). Screening should occur per “Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice” (http://pediatrics.aappublications.org/content/126/5/1032).

13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See “Promoting Optimal Development: Screening for Behavioral and Emotional Problems” (http://pediatrics.aappublications.org/content/137/1/27.full) and “Poverty and Child Health in the United States” (http://pediatrics.aappublications.org/content/124/4/1226.full).


16. Screening should occur per “Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice” (http://pediatrics.aappublications.org/content/126/5/1032).

17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and nudity draped. See “Use of Dispositional Physical Examination of the Pediatric Patient” (http://pediatrics.aappublications.org/content/127/7/991.full).

18. These may be modified, depending on entry point into schedule and individual need.

(continued)
DEPRESSION SCREENING
- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING
- Screening for maternal depression at 1, 2, 4, and 6-month visits has been added.
- Footnote 16 was added to read as follows: “Screening should occur per Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice” (http://pediatrics.aappublications.org/content/126/5/1823).

NEWBORN BLOOD SCREENING
- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been added to read as follows: “Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/services/taskforce/uspstf/uniformscreeningpanel.pdf) establishes the criteria for and coverage of newborn screening procedures and programs.”
- Footnote 20 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

NEWBORN BILIRUBIN
- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: “Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See ‘Hyperbilirubinemia in the Newborn Infant ≥35 Weeks’ Gestation: An Update With Clarifications’” (http://pediatrics.aappublications.org/content/134/3/626).

DYSLIPIDEMIA
- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS
- Footnote 29 has been updated to read as follows: “Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.”
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: “Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/usps/uspshiv.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be offered HIV screening annually.”

NEWBORN SCREENING
- For child risk of lead exposure, see “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” (http://www.cdc.gov/nceh/lead/ACCLPP/ Final_Document_030712.pdf).
- For fluoride use in caries prevention, see “‘Fluoride Use in Caries Prevention in the Primary Care Setting’” (http://pediatrics.aappublications.org/content/134/3/626).
- Footnote 35 has been added to read as follows: “If primary water source is deficient in fluoride, consider oral fluoride supplementation. See ‘Fluoride Use in Caries Prevention in the Primary Care Setting’” (http://pediatrics.aappublications.org/content/134/3/626).
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(For those who fall behind or start late, see the catch-up schedule [Figure 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B’ (HepB)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td>5th dose</td>
<td></td>
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<tr>
<td>Rotavirus’ (RV) (2-dose series); RV5 (3-dose series)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td>See footnote 2</td>
<td></td>
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<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis’ (DTaP; &lt;7 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td>5th dose</td>
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<tr>
<td>Haemophilus influenzae type b’ (Hib)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>See footnote 4</td>
<td>3rd or 4th dose</td>
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<tr>
<td>Pneumococcal conjugate’ (PCV13)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td></td>
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<tr>
<td>Inactivated poliovirus’ (IPV; &lt;18 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td>3rd dose</td>
<td>4th dose</td>
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<td>Influenza’ (IIV)</td>
<td>Annual vaccination (IIV) 1 or 2 doses</td>
<td>Annual vaccination (IIV) 1 dose only</td>
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<tr>
<td>Measles, mumps, rubella’ (MMR)</td>
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<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
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<tr>
<td>Varicella’ (VAR)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
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<tr>
<td>Hepatitis A’ (HepA)</td>
<td></td>
<td></td>
<td></td>
<td>2nd dose</td>
<td>3rd dose</td>
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<tr>
<td>Meningococcal 11’ (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
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<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis’ (Tdap; ≥7 yrs)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
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<td>Human papillomavirus’ (HPV)</td>
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<td>See footnote 12</td>
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<tr>
<td>Pneumococcal polysaccharide’ (PPS23)</td>
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<td></td>
<td></td>
<td>See footnote 5</td>
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NOTE: The above recommendations must be read along with the footnotes of this schedule.

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The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

### Children age 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Dose 1 to Dose 2</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks and at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.</td>
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</tr>
<tr>
<td>Rotavirus&lt;sup&gt;2&lt;/sup&gt;</td>
<td>6 weeks; Maximum age for first dose is 14 weeks, 6 days</td>
<td>4 weeks</td>
<td>4 weeks Maximum age for final dose is 8 months, 0 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis&lt;sup&gt;3&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b&lt;sup&gt;3&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks. if current age is younger than 12 months and first dose was administered at younger than age 7 months, and at least 1 previous dose was PRP-T (ActHib, Pentacel, Hibrix) or unknown.</td>
<td></td>
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<tr>
<td>Pneumococcal conjugate&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks. if current age is younger than 12 months and previous dose given at &lt;7 months old.</td>
<td></td>
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<td></td>
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<tr>
<td>Inactivated poliovirus&lt;sup&gt;5&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks (as final dose)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;6&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
<td>6 months (as final dose) if current age is 4 years or older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;8&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;9&lt;/sup&gt; (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)</td>
<td>6 weeks</td>
<td>8 weeks&lt;sup&gt;11&lt;/sup&gt;</td>
<td>See footnote 11</td>
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</tbody>
</table>

### Children and adolescents age 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Dose 1 to Dose 2</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal&lt;sup&gt;11&lt;/sup&gt; (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos) Not Applicable (N/A)</td>
<td>8 weeks&lt;sup&gt;11&lt;/sup&gt;</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis&lt;sup&gt;12&lt;/sup&gt;</td>
<td>7 years&lt;sup&gt;13&lt;/sup&gt;</td>
<td>4 weeks</td>
<td>4 weeks. if first dose of DTaP/DT was administered before the 1st birthday.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus&lt;sup&gt;14&lt;/sup&gt;</td>
<td>9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;10&lt;/sup&gt;</td>
<td>N/A</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;7&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
<td>8 weeks and at least 16 weeks after first dose.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;6&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;6&lt;/sup&gt;</td>
<td>N/A</td>
<td>4 weeks</td>
<td>A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>N/A</td>
<td>3 months if younger than age 13 years.</td>
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NOTE: The above recommendations must be read along with the footnotes of this schedule.
## Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications

<table>
<thead>
<tr>
<th>VACCINE 🗑️</th>
<th>INDICATION 🗳️</th>
<th>Pregnancy</th>
<th>Immunocompromised status (excluding HIV infection)</th>
<th>HIV infection CD4+ count†</th>
<th>Kidney failure, end-stage renal disease, on hemodialysis</th>
<th>Heart disease, chronic lung disease</th>
<th>CSF leaks/cochlear implants</th>
<th>Asplenia and persistent complement component deficiencies</th>
<th>Chronic liver disease</th>
<th>Diabetes</th>
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<tbody>
<tr>
<td>Hepatitis B¹</td>
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<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis³ (DTaP)</td>
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<tr>
<td><em>Haemophilus influenzae</em> type b⁴</td>
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<td>Inactivated poliovirus⁶</td>
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<tr>
<td>Influenza⁷</td>
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<tr>
<td>Measles, mumps, rubella⁸</td>
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<td>Varicella⁹</td>
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<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis¹² (Tdap)</td>
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<tr>
<td>Human papillomavirus¹³</td>
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<tr>
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</table>

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

*Severe Combined Immunodeficiency

†For additional information regarding HIV laboratory parameters and use of live vaccines; see the General Best Practice Guidelines for Immunization “Altered Immunocompetence” at: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html); and Table 4-1 (footnote D) at: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html).
Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information; see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)
   
   **Birth Dose (Monovalent HepB vaccine only):**
   - **Mother is HBsAg-Negative:** 1 dose given in 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.
   
   **Mother is HBsAg-Positive:**
   - Give HepB vaccine and 0.5 mL of HBIG (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
   - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
   
   **Mother's HBsAg status is unknown:**
   - Give HepB vaccine within 12 hours of birth, regardless of birth weight.
   - For infants <2,000 grams, give 0.5 mL of HBIG in addition to HepB vaccine within 12 hours of birth.
   - Determine mother’s HBsAg status as soon as possible. If mother is HBsAg-positive, give 0.5 mL of HBIG to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

   **Routine Series:**
   - A complete series is 3 doses at 0, 1–2, and 6–18 months. (Monovalent HepB vaccine should be used for doses given before age 6 weeks.)
   - Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
   - Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
   - **Minimum age** for the final (3rd or 4th) dose: 24 weeks.
   - **Minimum Intervals:** Dose 1 to Dose 2: 4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute “Dose 4” for “Dose 3” in these calculations.)

   **Catch-up vaccination:**
   - Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
   - Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation Recombivax HB only).
   - For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)
   
   **Routine vaccination:**
   - 2-dose series at 2 and 4 months.
   - 3-dose series at 2, 4, and 6 months. If any dose in the series is either RotaTeq or unknown, default to 3-dose series.

   **Catch-up vaccination:**
   - Do not start the series on or after age 15 weeks, 0 days.
   - The maximum age for the final dose is 8 months, 0 days.
   - For other catch-up guidance, see Figure 2.

3. Diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])
   
   **Routine vaccination:**
   - 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years.
     - **Prospectively:** A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
     - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

   **Catch-up vaccination:**
   - The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
   - For other catch-up guidance, see Figure 2.
4. *Haemophilus influenzae* type b (Hib) vaccine. (minimum age: 6 weeks)

**Routine vaccination:**
- ActHIB, Hiberix, or Pentacel: 4-dose series at 2, 4, 6, and 12–15 months.
- PedvaxHIB: 3-dose series at 2, 4, and 12–15 months.

**Catch-up vaccination:**
- **1st dose at 7–11 months:** Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
- **1st dose at 12–14 months:** Give 2nd (final) dose at least 8 weeks after 1st dose.
- **1st dose before 12 months and 2nd dose before 15 months:** Give 3rd (final) dose 8 weeks after 2nd dose.
- **2 doses of PedvaxHIB before 12 months:** Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
- **Unvaccinated at 15–59 months:** 1 dose.
- For other catch-up guidance, see Figure 2.

**Special Situations:**
- Chemotherapy or radiation treatment (12–59 months)
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

*Doses given within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.*

- Hematopoietic stem cell transplant (HSCT)
  - 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant (regardless of Hib vaccination history).

- Anatomic or functional asplenia (including sickle cell disease) (12–59 months)
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

*Unimmunized persons 5–18 years*
  - Give 1 dose

**Immunoglobulin deficiency, early component complement deficiency** (12–59 months)
- Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
- 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

*Unimmunized = Less than routine series (through 14 months) OR no doses (14 months or older)*

5. **Pneumococcal vaccines. (minimum age: 6 weeks [PCV13], 2 years [PPSV23])**

**Routine vaccination with PCV13:**
- 4-dose series at 2, 4, 6, and 12–15 months.

**Catch-up vaccination with PCV13:**
- 1 dose for healthy children aged 24–59 months with any incomplete* PCV13 schedule
- For other catch-up guidance, see Figure 2.

**Special situations: High-risk conditions:**
- Administer PCV13 doses before PPSV23 if possible.

**Cerebrospinal fluid leak; cochlear implant:**

**Age 2–5 years:**
- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

**Age 6–18 years:**
- No history of either PCV13 or PPSV23: 1 dose of PCV13, 1 dose of PPSV23 at least 8 weeks later.
- Any PCV13 but no PPSV23: 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.

**Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:**

**Age 2–5 years:**
- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later.

**Age 6–18 years:**
- No history of either PCV13 or PPSV23: 1 dose of PCV13, 2 doses of PPSV23 (1st dose of PPSV23 administered 8 weeks after PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
- Any PCV13 but no PPSV23: 2 doses of PPSV23 (1st dose of PPSV23 to be given 8 weeks after the most recent dose of PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

7. **Influenza vaccines. (minimum age: 6 months)**
   **Routine vaccination:**
   - Administer an age-appropriate formulation and dose of influenza vaccine annually.
   - **Children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
   - **Persons 9 years and older** 1 dose
   - Live attenuated influenza vaccine (LAIV) not recommended for the 2017–2018 season.
   (For the 2018–19 season, see the 2018–19 ACIP influenza vaccine recommendations.)

8. **Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months for routine vaccination)**
   **Routine vaccination:**
   - 2-dose series at 12–15 months and 4–6 years.
   - The 2nd dose may be given as early as 4 weeks after the 1st dose.

   **Catch-up vaccination:**
   - Unvaccinated children and adolescents: 2 doses at least 4 weeks apart.

9. **Varicella (VAR) vaccine. (minimum age: 12 months)**
   **Routine vaccination:**
   - 2-dose series: 12–15 months and 4–6 years.
   - The 2nd dose may be given as early as 3 months after the 1st dose (a dose given after a 4-week interval may be counted).

**Catch-up vaccination:**
- Ensure persons 7–18 years without evidence of immunity (see MMWR 2007;56[No. RR-4], at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine:
  - **Ages 7–12:** routine interval 3 months (minimum interval: 4 weeks).
  - **Ages 13 and older:** minimum interval 4 weeks.

10. **Hepatitis A (HepA) vaccine. (minimum age: 12 months)**
    **Routine vaccination:**
    - 2 doses, separated by 6-18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

    **Catch-up vaccination:**
    - Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses is 6 months.

**Special populations:**
Previously unvaccinated persons who should be vaccinated:
- Persons traveling to or working in countries with high or intermediate endemicity
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons who work with hepatitis A virus in a research laboratory or with non-human primates
- Persons with clotting-factor disorders
- Persons with chronic liver disease
- Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee’s arrival).

11. **Serogroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra].**
    **Routine:**
    - 2-dose series: 11-12 years and 16 years.

    **Catch-Up:**
    - Age 13-15 years: 1 dose now and booster at age 16-18 years. Minimum interval 8 weeks.
    - Age 16-18 years: 1 dose.

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**Chronic liver disease, alcoholism:**

**Age 6–18 years:**
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).
- *Incomplete schedules are any schedules where PCV13 doses have not been completed according to ACIP recommended catch-up schedules. The total number and timing of doses for complete PCV13 series are dictated by the age at first vaccination. See Tables 8 and 9 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?5_cid=mm6601a6_w). For other catch-up guidance, see Figure 2.

**Series Containing Oral Polio Vaccine (OPV), either mixed OPV-IPV or OPV-only series:**
- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?5_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as “OPV” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?5_cid=mm6606a7_w.
- For other catch-up guidance, see Figure 2.

**Inactivated poliovirus vaccine (IPV). (minimum age: 6 weeks)**

**Routine vaccination:**
- 4-dose series at ages 2, 4, 6–18 months, and 4–6 years.
- Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

**Catch-up vaccination:**
- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- If 4 or more doses were given before the 4th birthday, give 1 more dose at age 4–6 years and at least 6 months after the previous dose.
- A 4th dose is not necessary if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose.
- IPV is not routinely recommended for U.S. residents 18 years and older.

- **Infants 6–11 months:** 1 dose before departure. Revaccinate with 2 doses at 12–15 months (12 months for children in high-risk areas) and 2nd dose as early as 4 weeks later.
- **Unvaccinated children 12 months and older:** 2 doses at least 4 weeks apart before departure.

**Mumps outbreak:**
- Persons ≥12 months who previously received ≤2 doses of mumps-containing vaccine and are identified by public health authorities to be at increased risk during a mumps outbreak should receive a dose of mumps-virus containing vaccine.

**International travel:**
- **Infants 6–11 months:** 1 dose before departure. Revaccinate with 2 doses at 12–15 months and at least 6 months after the previous dose.
- **Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee’s arrival).**
Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):
- Menveo
  o 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  o 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  o 1st dose at 24 months or older: 2 doses at least 8 weeks apart.
- Menactra
  o Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart
    - 24 months or older: 2 doses at least 8 weeks apart.
  o Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart.
  o Menactra must be administered at least 4 weeks after completion of PCV13 series.

Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:
- Children <24 months of age:
  o Menveo (2–23 months):
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
    - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  o Menactra (9–23 months):
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
- Children 2 years or older: 1 dose of Menveo or Menactra.

Note: Menactra should be given either before or at the same time as DTap. For MenACWY booster dose recommendations for groups listed under “Special populations and situations” above, and additional meningococcal vaccination information, see meningococcal MMWR publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

12. Serogroup B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba]).
Clinical discretion: Adolescents not at increased risk for meningococcal B infection who want MenB vaccine.
MenB vaccines may be given at clinical discretion to adolescents 16–23 years (preferred age 16–18 years) who are not at increased risk.
- Bexsero: 2 doses at least 1 month apart.
- Trumenba: 2 doses at least 6 months apart. If the 2nd dose is given earlier than 6 months, give a 3rd dose at least 4 months after the 2nd.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, persistent complement component deficiency (including eculizumab use), serogroup B meningococcal disease outbreak:
- Bexsero: 2-dose series at least 1 month apart.
- Trumenba: 3-dose series at 0, 1-2, and 6 months.

Note: Bexsero and Trumenba are not interchangeable.
For additional meningococcal vaccination information, see meningococcal MMWR publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

13. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)
Routine vaccination:
- Adolescents 11–12 years of age: 1 dose.
- Pregnant adolescents: 1 dose during each pregnancy (preferably during the early part of gestational weeks 27–36).
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination:
- Adolescents 13–18 who have not received Tdap: 1 dose, followed by a Td booster every 10 years.
- Persons aged 7–18 years not fully immunized with DTap: 1 dose of Tdap as part of the catch-up series (preferably the first dose). If additional doses are needed, use Td.
- Children 7–10 years who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- DTap inadvertently given after the 7th birthday:
  o Child 7–10: DTap may count as part of catch-up series. Routine Tdap dose at 11-12 may be given.
  o Adolescent 11–18: Count dose of DTap as the adolescent Tdap booster.
  o For other catch-up guidance, see Figure 2.

14. Human papillomavirus (HPV) vaccine (minimum age: 9 years)
Routine and catch-up vaccination:
- Routine vaccination for all adolescents at 11–12 years (can start at age 9) and through age 18 if not previously adequately vaccinated. Number of doses dependent on age at initial vaccination:
  - Age 9–14 years at initiation: 2-dose series at 0 and 6–12 months. Minimum interval: 5 months (repeat a dose given too soon at least 12 weeks after the invalid dose and at least 5 months after the 1st dose).
  - Age 15 years or older at initiation: 3-dose series at 0, 1–2 months, and 6 months. Minimum intervals: 4 weeks between 1st and 2nd dose; 12 weeks between 2nd and 3rd dose; 5 months between 1st and 3rd dose (repeat dose(s) given too soon at or after the minimum interval since the most recent dose).
- Persons who have completed a valid series with any HPV vaccine do not need any additional doses.

Special situations:
- History of sexual abuse or assault: Begin series at age 9 years.
- Immunocompromised* (including HIV) aged 9–26 years: 3-dose series at 0, 1–2 months, and 6 months.
- Pregnancy: Vaccination not recommended, but there is no evidence the vaccine is harmful. No intervention is needed for women who inadvertently received a dose of HPV vaccine while pregnant. Delay remaining doses until after pregnancy. Pregnancy testing not needed before vaccination.

*See MMWR, December 16, 2016;65(49):1405–1408, at www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf.
## DISEASES OR SUSPECTED DISEASES TO BE REPORTED IMMEDIATELY BY TELEPHONE

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Reporting Requirements</th>
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<tbody>
<tr>
<td>ESCHERICHIA COLI: shiga toxin producing (STEC) including E. coli O157 *+</td>
<td>SHIGA TOXIN (detected in feces) +</td>
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<tr>
<td>HEMOLYTIC UREMIC SYNDROME</td>
<td>SMALLPOX (Variola) +</td>
</tr>
<tr>
<td>INFLUENZA NOVEL STRAINS,(human)</td>
<td>TULAREMIA, human +</td>
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<tr>
<td>MEASLES (Rubella) +</td>
<td>VIRAL HEMORRHAGIC FEVERS, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg Viruses) +</td>
</tr>
<tr>
<td>MENINGOCOCCAL INFECTION</td>
<td>YELLOW FEVER +</td>
</tr>
<tr>
<td>NOVEL VIRUS INFECTION with pandemic potential**</td>
<td>ZIKA VIRUS INFECTION +</td>
</tr>
<tr>
<td>PARALYTIC SHELLFISH POISONING</td>
<td>OCCURRENCE OF ANY UNUSUAL DISEASE</td>
</tr>
<tr>
<td>PLAGUE, Human or Animal +</td>
<td>OUTBREAKS OF ANY DISEASE (including Foodborne and any diseases not listed in Section 2500. Specify if institutional and/or community setting. Two or more cases from separate households = an outbreak.)</td>
</tr>
<tr>
<td>RABIES, Human or Animal +</td>
<td></td>
</tr>
<tr>
<td>SCOMBROID FISH POISONING</td>
<td></td>
</tr>
</tbody>
</table>

## DISEASES TO BE REPORTED IMMEDIATELY BY TELEPHONE

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTHRAX, human or animal+</td>
<td></td>
</tr>
<tr>
<td>BOTULISM (Infant, Foodborne, Wound)+</td>
<td></td>
</tr>
<tr>
<td>BRUCELLOSIS, human +</td>
<td></td>
</tr>
<tr>
<td>BRUCELLOSIS, animal (except infections due to Brucella canis)+</td>
<td></td>
</tr>
<tr>
<td>CHOLERA*</td>
<td></td>
</tr>
<tr>
<td>CIGUATERA FISH POISONING (Community acquired only)</td>
<td></td>
</tr>
<tr>
<td>DENGUE+</td>
<td></td>
</tr>
<tr>
<td>DIPHTHERIA+</td>
<td></td>
</tr>
<tr>
<td>DOMOCIC ACID POISONING (Amnesic shellfish poisoning)</td>
<td></td>
</tr>
<tr>
<td>ESCHERICHIA COLI: shiga toxin producing (STEC) including E. coli O157 *+</td>
<td></td>
</tr>
<tr>
<td>HEMOLYTIC UREMIC SYNDROME</td>
<td></td>
</tr>
<tr>
<td>INFLUENZA NOVEL STRAINS,(human)</td>
<td></td>
</tr>
<tr>
<td>MEASLES (Rubella) +</td>
<td></td>
</tr>
<tr>
<td>MENINGOCOCCAL INFECTION</td>
<td></td>
</tr>
<tr>
<td>NOVEL VIRUS INFECTION with pandemic potential**</td>
<td></td>
</tr>
<tr>
<td>PARALYTIC SHELLFISH POISONING</td>
<td></td>
</tr>
<tr>
<td>PLAGUE, Human or Animal +</td>
<td></td>
</tr>
<tr>
<td>RABIES, Human or Animal +</td>
<td></td>
</tr>
<tr>
<td>SCOMBROID FISH POISONING</td>
<td></td>
</tr>
</tbody>
</table>

## DISEASES TO BE REPORTED WITHIN SEVEN CALENDAR DAYS

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANAPLASMOSIS+</td>
<td>LEPROSY (Hansen’s Disease) +</td>
</tr>
<tr>
<td>BRUCELLOSIS, animal (except dogs) +</td>
<td>LEPTOSPIROSIS+</td>
</tr>
<tr>
<td>CHANCROID+</td>
<td>LYME DISEASE</td>
</tr>
<tr>
<td>CHLAMYDIA TRACHOMATIS Infection+ including Lymphogranuloma Venereum (LGV)</td>
<td>MUMPS+</td>
</tr>
<tr>
<td>COCCIDIODOMYCOSIS+</td>
<td>RESPIRATORY SYNCYTIAL VIRUS (RSV) (only report deaths in a patient &lt; 5 years of age)</td>
</tr>
<tr>
<td>CREUTZFELDT-JAKOB DISEASE (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</td>
<td>RICKETTSIAL DISEASES (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses +</td>
</tr>
<tr>
<td>CYCLOSPORIOSIS+</td>
<td>ROCKY MOUNTAIN SPOTTED FEVER+</td>
</tr>
<tr>
<td>CYSTITIS RUBOSA OR TENAISIS</td>
<td>RUBELLA (German Measles) +</td>
</tr>
<tr>
<td>EHRLICHIOSIS+</td>
<td>RUBELLA SYNDROME, Congenital</td>
</tr>
<tr>
<td>GIARDIASIS+</td>
<td>TETANUS</td>
</tr>
<tr>
<td>GONOCOCCAL INFECTION</td>
<td>TULAREMIA, animal +</td>
</tr>
<tr>
<td>HEPATITIS B (Specify acute case or chronic) 1++</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS C (Specify acute case or chronic) 2+</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS D (Delta) (Specify acute case or chronic) 3+</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS E, acute infection 1+</td>
<td></td>
</tr>
<tr>
<td>HUMAN IMMUNODEFICIENCY VIRUS (HIV), (Non-Acute Infection)</td>
<td></td>
</tr>
<tr>
<td>HUMAN IMMUNODEFICIENCY VIRUS (HIV) HIV stage 3 (formerly AIDS)</td>
<td></td>
</tr>
<tr>
<td>INFLUENZA</td>
<td></td>
</tr>
<tr>
<td>INFLUENZA (Deaths in laboratory-confirmed cases for ages 0-64 years)</td>
<td></td>
</tr>
<tr>
<td>LEGIONELLOSIS+</td>
<td></td>
</tr>
</tbody>
</table>

## REPORTABLE NON-COMMUNICABLE DISEASES AND CONDITIONS

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALZHEIMER’S DISEASE AND RELATED CONDITIONS</td>
<td></td>
</tr>
<tr>
<td>ANIMAL BITE (SEE REVERSE)</td>
<td></td>
</tr>
<tr>
<td>DISORDERS CHARACTERIZED BY LAPSES OF CONSCIOUSNESS (SEE REVERSE)</td>
<td></td>
</tr>
<tr>
<td>MICROCEPHALY (ANY CAUSE)***</td>
<td></td>
</tr>
<tr>
<td>PESTICIDE EXPOSURE (SEE REVERSE)</td>
<td></td>
</tr>
</tbody>
</table>

** Pandemic potential: The potential ability of a pathogen to spread easily and efficiently in the human population, crossing international borders, and usually affecting many people. Such pathogens may be associated with severe illness and death.

++ Acute HIV Infection: Detectable HIV-1 RNA or p24 antigen in serum or plasma in the setting of a negative or indeterminate HIV-1 antibody test result for patients tested using a currently approved HIV test algorithm, as defined in section 2641.57.

*** Locally reportable by order of the Riverside County Public Health Officer

Rev. 06/16
State law requires that health care providers report diseases of public health importance. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other persons knowing of a CASE OR SUSPECTED CASE of any of the following diseases or conditions are required to report them to the local Department of Public Health.

- §2500(b) It shall be the duty of every health care provider, knowing or in attendance on a case or suspected case of any of the diseases or conditions listed on the front, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed on the front may make such a report to the local health officer for the jurisdiction where the patient resides.
- §2500(c) The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.
- §2500(a)(14) “Health care provider” means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner or dentist.

HOW TO REPORT ALL DISEASES, EXCEPT HIV CASES:

Extremely urgent conditions: (i.e., Anthrax, Botulism, Brucellosis, Cholera, Dengue, Diphtheria, Outbreaks of any kind - including Foodborne, Plague, Rabies, Relapsing Fever, and Smallpox) are to be reported immediately by telephone, 24 hours a day, to the appropriate number.

Urgent conditions: Foodborne illnesses should be reported by telephone or fax within one (1) working day of identification of the case or suspected case.

Non-urgent conditions: are to be reported within seven (7) calendar days from the time of identification.

Although it is not mandatory at this time, health care providers are encouraged to enroll in the California Reportable Disease Exchange (CalREDIE) and submit reports electronically.

The appropriate Confidential Morbidity Report (CMR) form must be completely filled out. All of the requested information is essential, including the lab information for selected diseases. All phone, fax, and mailed reports are to be made to the Disease Control Office, with the following exceptions: Reports of sexually transmitted diseases are to be faxed to (951) 358-6007 or mailed to the STD Program Office.

Confidential Morbidity Report (CMR) forms are available online at www.rivco-diseasecontrol.org.

### HOW TO REPORT ALL HIV CASES:

Mail in a double envelope stamped “Confidential” TO:

HIV/STD Program
P.O. Box 7600
Riverside, CA 92513-7600
Phone: (951) 358-7820
Fax: (951) 358-6007

OR

FAX to (951) 358-6007
If faxing, please call (951) 358-7820 to confirm receipt

### ANIMAL BITE:

Animal bites by a species subject to rabies are reportable in order to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals identified or associated with a case or outbreak may be reported in order to locate potentially exposed persons. Reports of non-rabies biting animals must be reported immediately to the nearest local Animal Control Agency.

### PESTICIDE EXPOSURE:

The Health and Safety Code, Section 105200, requires that a physician who knows or who has reason to believe that a patient has a pesticide-related illness or condition must report the case to the local County Health Officer by phone within 24 hours. For occupational exposure there is an additional requirement to send the “Doctor’s First Report of Occupational Injury or Illness” to the Department of Public Health within 7 days. Phone reports may be made to (951) 358-5107; or faxed to (951) 358-5102. Copies of the required report forms (OEH-700 [Rev. 9/06] and California Form 5021 [Rev. 4] 1992) may be obtained from the same office.

Report form is available at http://www.oehha.ca.gov/pesticides/programs/Pestrep.html

### REPORTING DISORDERS CHARACTERIZED BY LAPSES OF CONSCIOUSNESS:

Health and Safety Code 103900 requires: Every physician and surgeon shall report immediately to the local health officer in writing, the name, date of birth, and address of every patient at least 14 years of age or older whom the physician and surgeon has diagnosed as having a case of a disorder characterized by lapses of consciousness. However, if a physician and surgeon reasonably and in good faith believes that the reporting of a patient will serve the public interest, he or she may report a patient’s condition even if it may not be required under the department’s definition of disorders characterized by lapses of consciousness pursuant to subdivision (d).
REPORTABLE DISEASES AND CONDITIONS
California Code of Regulations

WHY REPORT?

The primary objectives of disease surveillance are to (1) determine the extent of morbidity within the community, (2) evaluate risks of transmission, and (3) rapidly intervene when appropriate. The reporting of communicable diseases must be timely for surveillance to be effective. Confidentiality of patient information is always protected subject to compliance with disease control and other laws.

Delays or failure to report communicable diseases has contributed to serious outbreaks in the past. Removing persons from sensitive occupations, e.g., food handlers, prevents the spread of diseases such as salmonellosis and hepatitis A. The detection and treatment of patients with tuberculosis, the identification of asymptomatic carriers of typhoid fever and gonococcal infection, the immunization of persons exposed to vaccine-preventable diseases, and alerting healthcare providers about prevalent infections are just a few of the benefits derived by the entire community when reporting is timely and accurate. Failure to report can result in increased disease in the community, time lost from work or school, increased costs for diagnosis and treatment, hospitalization and possibly death.

Failure to report can also result in disciplinary action by the Board of Medical Quality Assurance (BMQA) for violation of Business and Professions Code, Section 2234 (Duty to Act, Unprofessional Conduct).
**§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

**URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]**

- **≠** Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ≠ in regulations).
- **⇒** Report by telephone within one working day of identification (designated by a + in regulations).
- **⇒** Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
- **⇒** All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

**REPORTABLE COMMUNICABLE DISEASES, §2500(k)(1)**

<table>
<thead>
<tr>
<th>FAX</th>
<th>≠</th>
<th>Amebiasis</th>
<th>≠</th>
<th>Aplastic Anemia</th>
<th>≠</th>
<th>Anthrax, human or animal</th>
</tr>
</thead>
<tbody>
<tr>
<td>≠</td>
<td>≠</td>
<td>Babesiosis</td>
<td>≠</td>
<td>Brucellosis, human</td>
<td>≠</td>
<td>Campylobacteriosis</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)</td>
<td>≠</td>
<td>Chikungunya Virus Infection</td>
<td>≠</td>
<td>Cholera</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Ciguatera Fish Poisoning</td>
<td>≠</td>
<td>Coccidiodermatitis</td>
<td>≠</td>
<td>Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Cryptosporidiosis</td>
<td>≠</td>
<td>Cyclosporiasis</td>
<td>≠</td>
<td>Cyclosporiasis</td>
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<tr>
<td>≠</td>
<td>≠</td>
<td>Bacterial vaginosis</td>
<td>≠</td>
<td>Cysticercosis or taeniasis</td>
<td>≠</td>
<td>Dengue Virus Infection</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Diphtheria</td>
<td>≠</td>
<td>Human Acute Acid Poisoning (Amnesic Shellfish Poisoning)</td>
<td>≠</td>
<td>! Escherichia coli: shiga toxin producing (STEC) including E. coli O157</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Vibrio Parahemolyticus</td>
<td>≠</td>
<td>! Enterohemorrhagic Escherichia coli (Shiga toxin-producing)</td>
<td>≠</td>
<td>! Flavivirus infection of undetermined species</td>
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<tr>
<td>≠</td>
<td>≠</td>
<td>! Foodborne Disease</td>
<td>≠</td>
<td>Giardiasis</td>
<td>≠</td>
<td>Giemiasis</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Gonococcal Infections</td>
<td>≠</td>
<td>Haemophilus influenzae, invasive disease, all serotypes (report an incident of less than five years of age)</td>
<td>≠</td>
<td>Hantavirus Infections</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>Hemolytic Uremic Syndrome</td>
<td>≠</td>
<td>Hepatitis A, acute infection</td>
<td>≠</td>
<td>! Hepatitis B, acute infection</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Hepatitis A, acute infection</td>
<td>≠</td>
<td>! Hepatitis C, acute infection</td>
<td>≠</td>
<td>! Hepatitis D (Delta), acute infection</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS)</td>
<td>≠</td>
<td>! Human Immunodeficiency Virus (HIV) infection, acute infection</td>
<td>≠</td>
<td>! Influenza, deaths in laboratory-confirmed cases for age 0-64 years</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Legionellosis</td>
<td>≠</td>
<td>! Legionellosis</td>
<td>≠</td>
<td>! Leprosy (Hansen Disease)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Leprosy (Hansen Disease)</td>
<td>≠</td>
<td>! Leptospirosis</td>
<td>≠</td>
<td>! Measles (Rubella)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Measles (Rubella)</td>
<td>≠</td>
<td>! Meningococcal Infections</td>
<td>≠</td>
<td>! Mumps</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Mumps</td>
<td>≠</td>
<td>! Novel Virus Infection with Pandemic Potential</td>
<td>≠</td>
<td>! Pertussis (Whooping Cough)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Pertussis (Whooping Cough)</td>
<td>≠</td>
<td>! Plague, human or animal</td>
<td>≠</td>
<td>! Poliomyelitis</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Poliomyelitis</td>
<td>≠</td>
<td>! Psittacosis</td>
<td>≠</td>
<td>! Q Fever</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Rabies, human or animal</td>
<td>≠</td>
<td>! Relapsing Fever</td>
<td>≠</td>
<td>! Respiratory Syncytial Virus (RSV)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Respiratory Syncytial Virus (RSV)</td>
<td>≠</td>
<td>! Richelotisch Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses</td>
<td>≠</td>
<td>! Rocky Mountain Spotted Fever</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Rubella (German Measles)</td>
<td>≠</td>
<td>! Rubela Syndrome, Congenital</td>
<td>≠</td>
<td>! Scombroid Fish Poisoning</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Shiga toxin (detected in feces)</td>
<td>≠</td>
<td>! Shigellosis</td>
<td>≠</td>
<td>! Smallpox (Variola)</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Smallpox (Variola)</td>
<td>≠</td>
<td>! Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</td>
<td>≠</td>
<td>! Syphilis</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Syphilis</td>
<td>≠</td>
<td>! Tetanus</td>
<td>≠</td>
<td>! Trichinosis</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Tuberculosis</td>
<td>≠</td>
<td>! Typhus, human, animal</td>
<td>≠</td>
<td>! Typhoid Fever, Cases and Carriers</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Typhus, human, animal</td>
<td>≠</td>
<td>! Vibrio Infections</td>
<td>≠</td>
<td>! Yellow Fever</td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</td>
<td>≠</td>
<td>! Yokel Virus Infection</td>
<td>≠</td>
<td>! Yersinios</td>
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<tr>
<td>≠</td>
<td>≠</td>
<td>! Yokel Virus Infection</td>
<td>≠</td>
<td>! OCCURRENCE OF ANY UNUSUAL DISEASE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≠</td>
<td>≠</td>
<td>! OUTBREAKS OF ANY DISEASE (Including diseases not listed in § 2500)</td>
<td>≠</td>
<td>! Outbreaks of ANY DISEASE (Including diseases not listed in § 2500)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20**

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and [http://www.cdph.ca.gov/programs/aids/Pages/TOAHIVRptgSP.aspx](http://www.cdph.ca.gov/programs/aids/Pages/TOAHIVRptgSP.aspx).

**REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)**

Disorders characterized by lapses of consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)•

Cancer, including benign and borderline brain tumors (except 1 basal and squamous skin cancer unless occurring on genitalia, and 2 carcinoma in-situ and CIN III of the Cervix) (§2593)**

**LOCALLY REPORTABLE DISEASES (if Applicable):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>= RSV became reportable on November 13, 2002 in San Bernardino County. RSV must be reported within seven (7) calendar days from the time of identification.</td>
</tr>
</tbody>
</table>

---

*This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

**Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

***The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrca.org.
Title 17, California Code of Regulations (CCR), Section 2505
REPORTABLE CONDITIONS: NOTIFICATION BY LABORATORIES
(June 2016)

California Code of Regulations, Title 17, Section 2505 requires laboratories to report laboratory testing results suggestive of the following diseases of public health importance to the local health department:

Subsection (e)(1) List
Anthrax, animal (B. anthracis)
Anthrax, human (B. anthracis)
Botulism
Brucellosis, human (all Brucella spp.)
Burkholderia pseudomallei and B. mallei
(detection or isolation from a clinical specimen)
Influenza, novel strains (human)
Plague, animal
Plague, human
Smallpox (Variola)
Tularemia, human (F. tularensis)
Viral hemorrhagic Fever agents, animal (VHF),
(e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
Viral Hemorrhagic Fever agents, human (VHF),
(e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)

Subsection (e)(2) List
Acid-fast bacillus (AFB)
Anaplasmosis
Babesiosis
Bordetella pertussis acute infection, by culture molecular identification
Borrelia burgdorferi infection
Brucellosis, animal (Brucella spp. except Brucella canis)
Campylobacteriosis (Campylobacter spp.) (detection or isolation from a clinical specimen)
Chancroid (Haemophilus ducreyi)
Chikungunya Virus Infection
Chlamydia trachomatis infections, including lymphogranuloma venereum
Coccidioidomycosis
Cryptosporidiosis
Cyclosporiasis (Cyclospora cayetanensis)
Dengue virus infection
Diphtheria
Ehrlichiosis
Encephalitis, arboviral
Entamoeba histolytica (Not E. dispar)
Escherichia coli: shiga toxin producing (STEC) including E. coli O157
Flavivirus infection of undetermined species
Giardiasis (Giardia lamblia, intestinalis, or duodenalis)
Gonorrhea
Haemophilus influenzae, all types (detection or isolation from a sterile site in a person less than five years of age)
Hantavirus Infections
Hepatitis A, acute infection
Hepatitis B, acute or chronic infection (specify gender)
Hepatitis C, acute or chronic infection
Hepatitis D (Delta), acute or chronic infection
Hepatitis E, acute infection (detection of hepatitis E virus RNA from a clinical specimen or positive serology)
Human Immunodeficiency Virus (HIV), acute infection
Legionellosis (Legionella spp.) (antigen or culture)
Leprosy (Hansen Disease) (Mycobacterium leprae)
Leptospirosis (Leptospira spp.)
Listeriosis (Listeria)
Malaria
Measles (Rubola), acute infection
Mumps (mumps virus), acute infection
Mycobacterium tuberculosis
Neisseria meningitidis (sterile site isolate)
Plague (Yersinia pestis), human or animal
Poliomyelitis
Psittacosis (Chlamydia psittaci)
Q Fever (Coxiella burnetii)
Rabies, animal or human
Relapsing Fever (Borreliosis spp.) (identification of Borrelia spp. spirochetes on peripheral blood smear)
Rickettsia, any species, acute infection (detection from a clinical specimen or positive serology)
Rocky Mountain Spotted Fever (Rickettsia rickettsii)
Rubella, acute infection
Salmonellosis (Salmonella spp.)
Shiga toxin (detected in feces)
Shigellosis (Shigella spp.)
Syphilis
Trichinosis (Trichinella)
Tuberculosis
Tularemia, animal (F. tularensis)
Typhoid
Vibrio species infections
West Nile virus infection
Yellow Fever (yellow fever virus)
Yersiniosis (Yersinia spp., non-pestis) (isolation from a clinical specimen)
Zika virus infection
Laboratory findings for these diseases are those that satisfy the most recent communicable disease surveillance case definitions established by the Centers for Disease Control and Prevention (unless otherwise specified in this Section). See also guidance at http://www.cdph.ca.gov/HealthInfo/Documents/LaboratoryReportableDiseasesInstructionsList-e2.pdf.

All laboratory notifications are acquired in confidence. The confidentiality of patient information is always protected.

WHEN TO REPORT (ALL DISEASES EXCEPT HIV ACUTE INFECTION)

These laboratory findings are reportable to the local health officer of the health jurisdiction where the health care provider who first submitted the specimen is located within one (1) hour (List (e)(1) diseases) or within one (1) working day (List (e)(2) diseases) from the time that the laboratory notifies that health care provider or other person authorized to receive the report. If the laboratory that makes the positive finding received the specimen from another laboratory, the laboratory making the positive finding shall notify the local health officer of the jurisdiction in which the health care provider is located within the time specified above from the time the laboratory notifies the referring laboratory that submitted the specimen. If the laboratory is an out-of-state laboratory, the California laboratory that receives a report of such findings shall notify the local health officer in the same way as if the finding had been made by the California laboratory.

HOW TO REPORT (ALL DISEASES EXCEPT HIV ACUTE INFECTION)

Laboratories can report results via electronic laboratory reporting (ELR) to the California Reportable Disease Information Exchange (CalREDIE). Laboratories unable to submit reports electronically must report on paper to the local health department.

Additional information about CalREDIE ELR can be found here: https://www.cdph.ca.gov/data/informatics/tech/Pages/CalREDIEELR.aspx

Reporting requirements for diseases and agents listed in Subsection (e)(1):
- Make initial report to the local health officer via telephone within one hour, and
- Report result(s) to CalREDIE within one working day of identification.

Reporting requirements for diseases and agents listed in Subsection (e)(2):
- Report result(s) to CalREDIE within one working day of identification.

HIV ACUTE INFECTION REPORTING REQUIREMENTS

In addition to routine reporting requirements set forth in section 2643.10, for acute HIV infection reporting, laboratories shall report all cases within one business day to the local health officer of the jurisdiction in which the patient resides by telephone. If the patient residence is unknown, the laboratory shall notify the health officer of the jurisdiction in which the health care provider is located. If evidence of acute HIV infection is based on presence of HIV p24 antigen, laboratories shall not wait until HIV-1 RNA is detected before reporting to the local health officer.

ADDITIONAL REPORTING REQUIREMENTS

ANTHRAX, BOTULISM, BRUCELLOSIS, GLANDERS, INFLUENZA, NOVEL STRAINS, MELIOIDOSIS, PLAGUE, SMALLPOX, TULaremia, and VIRAL HEMORRHAGIC FEvers

Whenever a laboratory receives a specimen for the laboratory diagnosis of a suspected human case of one of these diseases, such laboratory shall communicate immediately by telephone with the Microbial Diseases Laboratory (or, for Influenza, novel strains, Smallpox or Viral Hemorrhagic Fevers, with the Viral and Rickettsial Disease Laboratory) of the Department of Public Health for instruction. See also guidance at http://www.cdph.ca.gov/HealthInfo/Documents/LabReportingInstructionsList-e1SelectAgents.doc.pdf

TUBERCULOSIS (Section 2505 Subsections (f) and (g))

Any laboratory that isolates Mycobacterium tuberculosis from a patient specimen must submit a culture to the local public health laboratory for the local health jurisdiction in which the health care provider’s office is located as soon as available from the primary isolate on which a diagnosis of tuberculosis was established.

The information listed under “HOW TO REPORT” above must be submitted with the culture.

Unless drug susceptibility testing has been performed by the clinical laboratory on a strain obtained from the same patient within the previous three months or the health care provider who submitted the specimen for laboratory examination informs the laboratory that such drug susceptibility testing has been performed by another laboratory on a culture obtained from that patient within the previous three months, the clinical laboratory must do the following:

- Perform or refer for drug susceptibility testing on at least one isolate from each patient from whom Mycobacterium tuberculosis was isolated,
- Report the results of drug susceptibility testing to the local health officer of the city or county where the submitting physician’s office is located within one (1) working day from the time the health care provider or other authorized person who submitted the specimen is notified, and
If the drug susceptibility testing determines the culture to be resistant to at least isoniazid and rifampin, in addition, submit one culture or subculture from each patient from whom multidrug-resistant *Mycobacterium tuberculosis* was isolated to the local public health laboratory (as described above).

Whenever a clinical laboratory finds that a specimen from a patient with known or suspected tuberculosis tests positive for acid fast bacillus (AFB) staining and the patient has not had a culture which identifies that acid fast organism within the past 30 days, the clinical laboratory shall culture and identify the acid fast bacteria or refer a subculture to another laboratory for those purposes.

**MALARIA (Section 2505 Subsection (h))**

Any clinical laboratory that makes a finding of malaria parasites in the blood film of a patient shall immediately submit one or more such blood film slides for confirmation to the local public health laboratory for the local health jurisdiction where the health care provider is located. When requested, all blood films will be returned to the submitter.

**SALMONELLA (Section 2612)**

California Code of Regulations, Title 17, Section 2612 requires that a culture of the organisms on which a diagnosis of *salmonellosis* is established must be submitted to the local public health laboratory and then to the State’s Microbial Diseases Laboratory for definitive identification.

**Additional Specimens or Isolates to be Submitted to Public Health (Section 2505 Subsection (m)(1) and (m)(2) Lists)**

The following specimens or isolates must be submitted as soon as available to the local or state public health laboratory:

(m)(1) Specimens:
- HIV-1/2 antigen or antibody reactive sera or plasma submitted as part of a diagnostic HIV test algorithm, as defined in section 2641.57 (see (n) for additional reporting requirements)
- Malaria positive blood film slides (see (h) for additional reporting requirements)
- Measles immunoglobulin M (IgM)-positive sera
- Shiga toxin-positive fecal broths
- Zika virus immunoglobulin M (IgM)-positive sera

(m)(2) Isolates:
- Drug resistant *Neisseria gonorrhoeae* isolates (cephalosporin or azithromycin only)
- *Listeria monocytogenes* isolates
- *Mycobacterium tuberculosis* isolates (see (f) for additional reporting requirements)
- *Neisseria meningitides* isolates from sterile sites
- *Salmonella* isolates (see section 2612 for additional reporting requirements)
- Shiga toxin-producing *Escherichia coli* (STEC) isolates, including O157 and non-O157 strains
- *Shigella* isolates

**Additional Reporting Instructions for (m)(2) Isolates (Section 2505 Subsection (m)(3))**: If there is a laboratory test result indicating infection with any one of the pathogens listed in (m)(2), including identification of Shiga toxin in a clinical specimen, then the laboratory must attempt to obtain a bacterial culture isolate for submission to the public health laboratory in accordance with (m)(2). The laboratory shall take steps necessary to obtain an isolate, including requesting that additional specimens be collected and sending specimens to a laboratory able to carry out bacterial culture as soon as possible.

**Additional Reporting Instructions for HIV-1/2 Specimens (Section 2500 Subsection (n))**: A laboratory which receives a specimen that is reactive for HIV-1/2 antigen or antibody shall communicate with the Department’s Viral and Rickettsial Disease Laboratory for instructions on the specimen submission process. A laboratory shall also submit the Clinical Laboratory Improvement Amendments number.
HEALTH AND SAFETY CODE
SECTION 121361

121361. (a) (1) A health facility, local detention facility, or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:

(A) A person known to have active tuberculosis disease.

(B) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease.

(2) In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 121362 is approved by a local health officer of the jurisdiction in which the health facility is located. Any treatment plan submitted for approval pursuant to this paragraph shall be reviewed by the local health officer within 24 hours of receipt of that plan.

(3) The approval requirement of paragraph (2) shall not apply to any transfer to a general acute care hospital when the transfer is due to an immediate need for a higher level of care, nor to any transfer from any health facility to a correctional institution. Transfers or discharges described in this paragraph shall occur only after the notification and treatment plan required by Section 121362 have been received by the local health officer.

(4) This subdivision shall not apply to any transfer within the state correctional system or to any interfacility transfer occurring within a local detention facility system.

(b) No health facility shall, without first complying with subdivision (e), transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to another health facility. This subdivision shall not apply to any transfer within the state correctional system or to any interfacility transfer occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written treatment plan are received by the chief medical officer of the local detention facility receiving the person.

(e) (1) Any discharge, release, or transfer described in subdivisions (a), (b), (c), and (d) may occur only after notification and a written treatment plan pursuant to Section 121362 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

(2) When a person described in paragraph (1) of subdivision (a) is released on parole from a state correctional institution, the
notification and written treatment plan specified in this subdivision shall be provided to both the local health officer for the county in which the parolee intends to reside and the local health officer for the county in which the state correctional institution is located.

(3) Notwithstanding any other provision of law, the Department of Corrections shall inform the parole agent, and other parole officials as necessary, that the person described in paragraph (1) of subdivision (a) has active or suspected active tuberculosis disease and provide information regarding the need for evaluation or treatment. The parole agent and other parole officials shall coordinate with the local health officer in supervising the person's compliance with medical evaluation or treatment related to tuberculosis, and shall notify the local health officer if the person's parole is suspended as a result of having absconded from supervision.

(f) No health facility that declines to discharge, release, or transfer a person pursuant to this section shall be civilly or criminally liable or subject to administrative sanction therefor. This subdivision shall apply only if the health facility complies with this section and acts in good faith.

(g) Nothing in this section shall relieve a local health officer of any other duty imposed by this chapter.
WIC REFERRAL FOR POSTPARTUM / BREASTFEEDING WOMAN

Health Care Provider:
Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

<table>
<thead>
<tr>
<th>Patient’s name (last, first)</th>
<th>Address (street, city, ZIP code)</th>
<th>Telephone number</th>
<th>Birthdate</th>
</tr>
</thead>
</table>

**WOMAN’S CURRENT (After Delivery)**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Hemoglobin and/or</th>
<th>Hematocrit</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ ins.</td>
<td>_______ lbs.</td>
<td>_______ gm/dl.</td>
<td>_______ %</td>
</tr>
</tbody>
</table>

**PREGNANCY OUTCOME**

<table>
<thead>
<tr>
<th>Full-Term</th>
<th>Preterm (37 wks.)</th>
<th>Sm. Gest.</th>
<th>Fetal Loss</th>
<th>Stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
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</tr>
</tbody>
</table>

**Local WIC Agency**

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

- C-Section
- Other conditions occurring during this pregnancy or delivery
- Diabetes (specify):
- Hypertension
- Tuberculosis
- Other current or historical medical conditions (specify):
- +PPD
- +INH

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

<table>
<thead>
<tr>
<th>PREGNANCY OUTCOME</th>
<th>Delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

**PREGNANCY OUTCOME**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Birth weight</th>
<th>Birth length</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**LOCAL WIC AGENCY**

Name of physician/health care provider/group/clinic

Telephone number:

**IMPORTANT:** Must be signed by health care provider

Date

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA’s TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.
WIC REFERRAL FOR PREGNANT WOMAN

Health Care Provider:
Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

<table>
<thead>
<tr>
<th>Patient's name (last, first)</th>
<th>Address (street, city, ZIP)</th>
<th>Telephone number</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC'S CURRENT (PRENATAL)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height __________ ins.</td>
<td>__________ / __________ / __________</td>
<td>Hemoglobin __________gm/dl. __________ / __________ / __________</td>
<td>Est. date confinement __________ / __________ / __________</td>
</tr>
<tr>
<td>Measurement date</td>
<td></td>
<td>Blood test date</td>
<td>Date last preg. ended __________ / __________ / __________</td>
</tr>
<tr>
<td>Weight __________ lbs.</td>
<td></td>
<td>Hematocrit __________%</td>
<td>Gravida __________ Para __________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pregravid weight __________ lbs.</td>
</tr>
</tbody>
</table>

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:
☐ Diabetes  ☐ Multiple Pregnancy
☐ Hypertension  ☐ Tuberculosis   ☐ PPD   ☐ INH
☐ Previous poor pregnancy outcome / history (specify): ________________________________
☐ Other current or historical conditions (specify): ________________________________

PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:
______________________________________________________________________________
______________________________________________________________________________

IMPRESSIONS / COMMENTS:
______________________________________________________________________________
______________________________________________________________________________

LOCAL WIC AGENCY

Name of physician / health care provider / group / clinic

Telephone Number:

IMPORTANT: Must be signed by health care provider

Date

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA’s TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.
**Pediatric Referral**

**SECTION I:** Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula or medical food is prescribed, complete both Sections I and II.

<table>
<thead>
<tr>
<th>PATIENT NAME (First)</th>
<th>(Last)</th>
<th>DATE OF BIRTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

**CURRENT (within 60 days) HEIGHT/LENGTH**

<table>
<thead>
<tr>
<th>inches</th>
<th>lb</th>
<th>oz</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CURRENT (within 60 days) WEIGHT**

<table>
<thead>
<tr>
<th>lb</th>
<th>oz</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEASUREMENT DATE**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**BIRTH WEIGHT/LENGTH:**

<table>
<thead>
<tr>
<th>lb</th>
<th>oz</th>
<th>inches</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEMOGLOBIN OR HEMATOCRIT TEST** is required every 12 months when normal and every 6 months when abnormal.

<table>
<thead>
<tr>
<th>Hemoglobin (g/dl) or Hematocrit (%)</th>
<th>Lab</th>
<th>Result</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**LEAD TEST** (recommended at 1-2 years of age): ______ mcg/dL

**IMMUNIZATIONS** are up-to-date:

- [ ] Yes
- [ ] No
- [ ] Not available

**SECTION II:** Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information delays issuance of WIC foods.

**DIAGNOSIS:**

- [ ] Prematurity
- [ ] Failure to thrive
- [ ] GERD or reflux
- [ ] Dysphagia
- [ ] Food allergy: __________
- [ ] Other: __________

**FORMULA / MEDICAL FOOD:**

| Duration: | ______ months |
| AMOUNT: | ______ oz / day |
| This prescription is: | [ ] New | [ ] Refill |

**NOTE:** The patient will receive 13 quarts of cow’s milk in addition to therapeutic formula unless Do Not Give is checked for cow’s milk. Please see WIC Food Restrictions.

**WIC FOOD RESTRICTIONS:** The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

<table>
<thead>
<tr>
<th>Category</th>
<th>WIC Foods</th>
<th>Do Not Give</th>
<th>Restriction/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infants</strong> (6-12 mo)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby fruit/vegetable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children</strong> (1-5 yr)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut butter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole grains *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables/fruits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal

**HEALTH COVERAGE:** Refer the patient to the health plan or Medi-Cal for a medically necessary formula or medical food. WIC only provides these products when they are NOT a covered benefit by the patient’s health plan or by Medi-Cal.

Provide patient’s health insurance information: Check action taken:

<table>
<thead>
<tr>
<th>Private insurance:</th>
<th>Submitted justification to health plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal managed care:</td>
<td>Submitted justification to pharmacist</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Regular Medi-Cal (fee-for-service) |

If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:

- [ ] Gave formula samples
- [ ] Referred to Medi-Cal
- [ ] Referred to WIC

**QUESTIONS:** Call 1-888-942-9675 or 1-800-852-5770. Health professionals: Go to www.wicworks.ca.gov; click Health Professionals; then click WIC contacts for MDs.

**COMMENTS:**

<table>
<thead>
<tr>
<th>HEALTH PROFESSIONAL NAME</th>
<th>MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH PROFESSIONAL SIGNATURE</td>
<td>TODAY'S DATE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
<th></th>
</tr>
</thead>
</table>

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