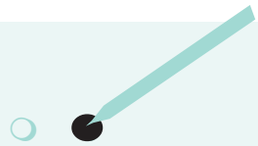
Magellan COMPLETE CARE®

Reference #:

Child Health Risk Screening



- Please fill in your responses like this using ONLY A BLUE OR BLACK PEN.
- Do NOT use GREEN INK.
- Please answer as many questions as you can.

Leave blank the question(s) you cannot or choose not to answer.

Your Child's Information

Child's Name: _____

Child's Address: _____

Child's Date of Birth: ☐☐ ☐☐ ☐☐☐☐
MM DD YYYY

What is your child's gender? ○ Male ○ Female

Phone number: ☐☐☐ ☐☐☐ ☐☐☐☐

Welcome to Magellan Complete Care of Virginia (MCC of VA)! We are glad to have you as a member and look forward to getting to know you. We'd like you to complete this form to tell us about your health so that we can help you in the ways you need. Please complete the form and return it to us in the enclosed postage-paid envelope.

We are excited to partner with you to help your child live a healthy life! To help us provide your child with the best service, please tell us about your child. All information you provide will be kept private. We will use the information you provide with your child's health care providers to help make sure your child has the health services that he or she needs.

If you do not want this information shared, please check the box below. Race, language, and other information will be used to make sure your child's health needs are met.

○ I do not want this information shared.

For members under the age of 18, please tell us who is completing this survey?

○ Health representative ○ Parent

1. Which option best describes your child's race?

○ American Indian/Alaskan Native ○ Asian ○ Black/African American ○ Hispanic/Latino
○ Native Hawaiian/Other Pacific Islander ○ White ○ Declined

2. What language(s) does your child speak?_____

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Child Health History

3. How much does your child weigh?

- ❍ I don't know

Pounds	
0 10 20 30 40 50 60 70 80 90	0 1 2 3 4 5 6 7 8 9
100 200 300 400 500 600 700	

4. How tall is your child?

- ❍ I don't know

Feet	Inches
0 1 2 3 4 5 6 7 8 9 10 11	
2 3 4 5 6 7	

5. Does your child have any of the special needs or disabilities listed below?

- ❍ Hearing Impairment
- ❍ Blind
- ❍ Physical
- ❍ Deaf
- ❍ Learning Disability
- ❍ Behavioral
- ❍ Vision Impairment
- ❍ None

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Child Health History (continued)

6. Has a doctor or other health care professional ever said your child has any of the following conditions? Fill in all that apply.

Asthma	❍ Yes	❍ No
Blood Disease (Hepatitis)	❍ Yes	❍ No
Cancer	❍ Yes	❍ No
Heart Conditions	❍ Yes	❍ No
HIV/AIDS	❍ Yes	❍ No
Low birth weight or other birth problems	❍ Yes	❍ No
Sleep problems	❍ Yes	❍ No
Tuberculosis	❍ Yes	❍ No
Autism or Autism Spectrum Disorders	❍ Yes	❍ No
Brain Injury	❍ Yes	❍ No
Depression	❍ Yes	❍ No
Diabetes or sugar in your child's blood	❍ Yes	❍ No
High blood pressure	❍ Yes	❍ No
Kidney disease/Dialysis	❍ Yes	❍ No
Obesity or that your child is overweight	❍ Yes	❍ No
Sickle Cell Disease	❍ Yes	❍ No
Might need a transplant or your child is on the transplant list	❍ Yes	❍ No

7. For female children old enough, is your child pregnant?

❍ Yes ❍ No ❍ I don't know

a. If yes, when is her due date? ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋ ❍ I don't know
MM DD YYYY

b. If yes, is she currently getting care from a doctor or other health care professional for her pregnancy?

❍ Yes ❍ No ❍ I don't know

c. If yes, does the provider have any concerns?

❍ Yes ❍ No ❍ I don't know

d. If yes (concerns), what are those concerns? ❍ Declined

_____

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Child Health History (continued)

8. Has your child had a medical checkup in the last 12 months?

❍ Yes ❍ No ❍ I don't know

9. Does your child have a primary care physician (PCP)? If not, does your child have a doctor to be their PCP?

❍ Yes ❍ No ❍ I don't know ❍ Declined

a. What is the doctor's name? _____

10. Is your child seeing any specialists?

❍ Yes ❍ No

a. If yes, what type of specialist?

❍ Cardiology ❍ Pulmonology ❍ Neurology ❍ Other
❍ Oncology ❍ Nephrology ❍ Endocrinology

b. Specialist Details (specialist name) _____

11. Does your child have surgery planned for the future?

❍ Yes ❍ No

a. What are the dates of the surgery planned for the future? |__|__| |__|__| |__|__|__|__|
MM DD YYYY

b. What type of surgery is that?

❍ Declined

_____

12. Please answer each question below that describes your child.

Does your child need or use medicine prescribed by a doctor (other than vitamins)?

❍ Yes ❍ No ❍ I don't know

Can you tell us what that medicine is and what it is used for?

_____

Does your child need or use medical equipment (such as, wheelchair, leg braces, nebulizer)?

❍ Yes ❍ No ❍ I don't know

a. If yes, was that prescribed by a doctor?

❍ Yes ❍ No ❍ I don't know

Does your child need or get special therapy, like physical, occupational or speech therapy?

❍ Yes ❍ No ❍ I don't know

Does your child need or get treatment or counseling for an emotional, developmental or behavioral problem?

❍ Yes ❍ No ❍ I don't know

Reference #:

Child Health History (continued)

13. In the past 12 months, how many times has your child:

Gone to the Emergency Room?

❍ None ❍ 1 to 2 ❍ 3 to 5 ❍ 6 or more ❍ I don't know

Stayed overnight in a hospital?

❍ None ❍ 1 to 2 ❍ 3 to 5 ❍ 6 or more ❍ I don't know

14. Is your child getting home care or home hospice care?

❍ Yes ❍ No

15. Is your child receiving Part C services?

❍ Yes ❍ No ❍ I don't know

16. For children ages 10 and above only, please fill in all that apply below.

During the past 12 months, did your child:

- ❍ Smoke or use tobacco products
- ❍ Drink alcohol (more than a few sips)
- ❍ Smoke or use marijuana
- ❍ Use anything else to get high ("Anything else" includes illegal drugs, over-the-counter and prescription drugs, and/or things that you sniff or huff)
- ❍ I don't know
- ❍ Does not apply

17. Does your child need help in any of the following areas?

- ❍ Eating healthy
- ❍ Exercising or increasing physical activity
- ❍ Getting to or maintaining a healthy weight
- ❍ Managing stress
- ❍ Stop using drugs or alcohol
- ❍ Stop smoking or chewing tobacco
- ❍ None
- ❍ I don't know