10. MEDICAL CARE STANDARDS

A. Initial Preventive Physical Exam

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Primary Care Providers (PCPs) are expected to schedule and provide an Initial Preventive Physical Exam (IPPE) for all IEHP DualChoice Members within twelve (12) months of the Member's enrollment.[1,2]

PROCEDURES:

A. An IPPE consists of the following components:[3]
   1. Review of comprehensive medical and social history;
   2. Review of risk factors for depression and other behavioral health conditions;
      a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations. Examples include the PHQ-9 for depression screening and the GAD-7 for anxiety disorder screening.
   3. Review of functional ability and level of safety;
      a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations to assess for hearing impairment, activities of daily living, fall risk and home safety. Examples include an audiogram for hearing impartment, the "Timed Up and Go Test" for assessment of fall risk, the Katz ADL Index, the Lawton-Brody I-ADL Scale, and the Westmead Home Safety Assessment.
   4. Examination - Obtain the following:
      a. Height, Weight, body mass index, and blood pressure;
      b. Visual acuity screen; and
      c. Other factors deemed appropriate based on the Member's medical and social history and current clinical standards.
   5. End of life planning (upon agreement with the Member);
      a. Verbal or written information provided to the Member about advanced directives.
   6. Review current opioid prescriptions (if it applies);
   7. Screen for potential substance abuse disorders (SUD);

[1] Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 611
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[3] Title 42, Code of Federal Regulations (CFR) § 410.16

8. Brief education, counseling, and referral to address any pertinent health issues identified during the first five (5) components of the exam; and
9. Brief education, counseling, and referral, with maintenance of a written plan regarding separate preventive care services covered by Medicare Part B.
    a. For Members 18 years of age or older, 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. Services with a grade "A" or "B" USPSTF designation are recommended to be offered or provided.[4]
    b. 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 (See Attachment, "Recommended Immunizations for Adults" in Section 10).[5]

B. Specific components of health assessments are also found in Policy 10B, "Adult Preventive Services."

C. PCPs must give each Member a written plan for obtaining the appropriate preventive services.

D. PCPs must maintain documentation of the IPPE in the Member medical record and maintained by the PCP office for a minimum of ten (10) years. The Member's chart must be maintained according to Policy 7A, "PCP and IPA Medical Record Requirements."

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[4] U.S. Preventive Services Task Force (USPSTF), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

[5] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. For adult Members, Primary Care Providers (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.[1] All preventive services with a grade of "A" or "B" must be offered or provided and do not require prior authorization.[2]

B. IEHP requires all IEHP network Providers to provide immunization services according to the most recent U.S. Public Health Service's Advisory Committee on Immunization Practice (ACIP) recommendations.[3] 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.

PROCEDURES:

Health Assessments

A. PCPs are required to provide an Initial Preventive Physical Exam (IPPE) within twelve (12) months of enrollment to all IEHP DualChoice Members assigned to them as outlined in Policy 10A, "Initial Preventive Physical Exam."[4,5]

B. PCPs are required to provide an Initial Health Assessment (IHA) within one hundred twenty (120) calendar days of enrollment to all DualChoice Members assigned to them as outlined in Policy 10C, "Initial Health Assessment."

C. PCPs are required to provide targeted history and physical examinations focused on the needs and risk factors of Members on an annual basis. History and physical examinations must include, at a minimum:[6]

   1. Comprehensive (initial) or interim medical history including history of illness, past medical history, social history, and review of organ systems;

[1] U.S. Preventive Services Task Force (USPSTF) http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
[2] U.S. Preventive Services Task Force (USPSTF) A and B Recommendations http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[3] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf
[4] Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 611
[5] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[6] Agency for Healthcare Research and Quality. Guide to Clinical Preventive Services, 2014. Web. June 2014. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

2. Staying Healthy Assessment (SHA) using the age appropriate "Staying Healthy Assessment" tool as outlined in Policy 15G, "Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA);"
3. Physical exam – Either comprehensive (initial) or targeted (interim) addressing all appropriate parts of the body and organ systems, including screening for high blood pressure, pulse, respiratory rate, temperature, height and weight, and BMI;
4. Dental screening – An oral survey for teeth, gum or oral cavity related illnesses or injuries; and
5. Vision and hearing screening as appropriate for age.

D. 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 episodic basis. For Members that they have never seen, PCPs are required to actively outreach to Members when they first enroll to schedule the Initial Health Assessment within one hundred twenty (120) calendar days of their enrollment. See Policy 10C, "Initial Health Assessment."

E. 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.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

A. SABIRT services may be provided by Providers in primary care setting and within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.

B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of age and older, including pregnant women as follows:

1. When the Member responds affirmatively to the alcohol pre-screen question on the SHA, the PCP must conduct screening for unhealth alcohol and drug use using validated screening tools, including but not limited to:
    a. Alcohol Use Disorders Identification Test (AUDIT-C) (see Attachment, "AUDIT-C" in Section 12);
    b. Brief Addiction Monitor (BAM) (see Attachment, "Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" in Section 12);
    c. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID);
    d. Tobacco Alcohol, Prescription Medications and other Substances (TAPS);
    e. National Institute on Drug Abuse (NIDA) Quick Screen for Adults (The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening);
    f. Drug Abuse Screening Test (DAST-10);

g. Parents, Partner, Past and Present (4Ps) for pregnant women; and

h. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol and drug assessment tools include, but are not limited to:

   a. Alcohol Use Disorders Identification Test (AUDIT);

   b. Brief Addiction Monitor (BAM) (see Attachment, "Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" in Section 12);

   c. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST); and

   d. Drug Abuse Screening Test (DAST-20).

3. The PCP must offer immediate brief misuse counseling when a Member reveals unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to Members whose brief assessment demonstrates possible alcohol use disorder (AUD) or substance use disorder (SUD). Brief interventions must include the following:

   a. Providing feedback to the Member regarding screening and assessment results;

   b. Discussing negative consequences that have occurred and overall severity of the problem;

   c. Supporting the Member in making behavioral changes; and

   d. Discussing and agreeing on plans for follow-up with the Member, including referral to other treatment if indicated.

4. The PCP must ensure the Member's medical record include the following:

   a. The service provided (e.g., screen and brief intervention);

   b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

   c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and

   d. If and where a referral to an AUD or SUD program was made.

5. IEHP will make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred treatments, IEHP will follow up with the Member to understand barriers and make adjustments to the referrals as needed. IEHP may also attempt to connect with the Provider to whom the Member was referred to facilitate a

warm hand-off to necessary treatment.

Tobacco Prevention and Cessation

A. Providers must identify and track all tobacco use, both initial and annually, through the following activities:
   1. Completion of the IHA and SHA questionnaire, which asks about smoking status and/or exposure to tobacco smoke;
   2. Annual assessment of tobacco use based on the SHA periodicity schedule, unless an assessment needs to be readministered; and
   3. Asking Members about their current tobacco use and documenting in their medical record at every visit.

B. Providers must review the questions on tobacco with the Member, which constitutes as individual counseling.

C. With regard to Members identified as using tobacco products, IEHP encourages Providers to implement the following interventional approach:[7]
   1. Providers are encouraged to use a validated behavior change model to counsel Members who use tobacco products. Training materials for the following examples may be requested from IEHP by calling the Provider Relations Team at (909) 890-2054 or accessed online through the IEHP website at www.iehp.org:
      a. Use of the "5 A's" – Ask, Advise, Assess, Assist, and Arrange; and
      b. Use of the "5 R's" – Relevance, Risks, Rewards, Roadblocks, and Repetition.
   2. Members can 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 without any mandatory breaks between quit attempts.
      a. The lists of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco use may be accessed online through the IEHP non-secure Provider portal at www.iehp.org.
   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.

[7] Agency for Healthcare Research and Quality. Guide to Clinical Preventive Services, 2014. Web. June 2014. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

Immunizations

A. 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 (See Attachment, "Recommended Adult Immunization Schedule" in Section 10).[8]

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[8] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

10. MEDICAL CARE STANDARDS

C. Initial Health Assessment

APPLIES TO:

A. This policy applies to IEHP DualChoice Members and Providers.

POLICY:

A. IEHP and its IPAs ensure that all new Members have an Initial Health Assessment (IHA) completed during the Member's initial encounter(s) with their Primary Care Provider (PCP).[1]

DEFINITION:

A. Initial Health Assessment (IHA) – The IHA is a comprehensive assessment that is completed during the Member's initial encounter(s) with a selected or assigned Primary Care Provider (PCP), appropriate medical specialist, or non-physician medical provider (NPMP) that is documented in the Member's medical record. The IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA). The IHA enables the Member's PCP to assess and manage the acute, chronic, and preventive health needs of the Member, and identify those Members whose health needs require coordination with appropriate community resources and other agencies.[2]

PROCEDURES:

Components of the IHA

A. An IHA consists of the following components:[3]

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);
7. Physical exam (including mental status) sufficient to assess the Member's acute, chronic, preventive health needs, and psychosocial needs;
8. Diagnostic tests - ordering of appropriate diagnostic tests, as needed; and

[1] Department of Health Care Services (DHCS) Policy Letter (PL) 08-003, "Initial Comprehensive Health Assessment"
[2] Ibid.
[3] Ibid.

9. Development of Problem List and Medication List, if appropriate.

B. All Members must receive the Staying Healthy Assessment (SHA) as part of their IHA.[4] See Policy 15G, "Individual Health Education Behavioral Assessment (IHEBA) and Staying Healthy Assessment (SHA)," for more information on administering SHAs.

Timelines for IHA Completion

A. IEHP Members are notified of the availability and need for their PCP to schedule and conduct the IHA within one hundred twenty (120) calendar days of enrollment.[5]

B. If the member requests or the plan initiates a change in their PCP within the first one hundred twenty (120) days of their enrollment with IEHP and the IHA has not yet been completed, an IHA still needs to be completed by the newly assigned PCP within the timeframes set forth in this policy.[6]

Provider Responsibilities

A. PCPs are required to have specific policies and procedures in place to notify Members to come in for their IHA, timeline for its completion, and facilitate the Member's access to an IHA.[7] PCPs may work in collaboration with their IPA to meet this requirement.

1. PCP offices must maintain documentation of these notifications (i.e., letters to all Members, active or not, informing them of the need for an IHA) 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 medical record and maintained 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 the same policy.

B. PCPs are responsible for assessing Members of the need for an IHA and scheduling accordingly, any time they see the Member for an acute or chronic illness. If the Member has had an IHA within twelve (12) months of their enrollment, the PCP must document the specifics in the Member's medical record.[8]

C. PCPs are responsible for retaining the Member's completed IHA and IHEBA/SHA in the Member's medical record to be available during subsequent preventive health visits.

D. PCPs are responsible for accessing a current list of their Members eligible for an IHA through the secure IEHP Provider portal.

E. PCPs are responsible for follow-up of missed appointments, as outlined in Policy 9B, "Missed Appointments."

F. PCPs are responsible for providing preventive services at the time of IHA completion or arranging follow-up visits or referrals for Members that have significant health problems

[4] DHCS PL 08-003
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.

identified during the IHA. For information on age-specific preventive are guidelines and services, please see Policy 10B, "Adult Preventive Services."

Provider Training[9]

A. IEHP provides IHA training to all Providers and their staff regarding:

1. Adequate documentation of IHAs or the reasons IHAs were not completed;
2. Timelines for performing IHAs; and
3. Procedures to assure that visit(s) for the IHA are scheduled and that Members are contacted about missed IHA appointments.

Exceptions from IHA Requirements

A. Exceptions from the timeline requirements described in this policy can occur only in the following situations, and only if documented in the Member's medical record:[10]

1. All elements of the IHA were completed within twelve (12) months prior to the Member's enrollment with IEHP. If the PCP did not perform the IHA, he or she must document in the Member's medical record that the findings have been reviewed and updated accordingly.
2. The PCP may incorporate relevant patient historical information from the Member's old medical record. However, the PCP must conduct an updated physical examination if the Member has not had a physical examination within twelve (12) months of the Member's enrollment with IEHP.
3. The Member was not continuously enrolled with IEHP for one hundred twenty (120) days.
4. The Member was disenrolled from IEHP before an IHA could be performed.
5. The Member refuses an IHA.
6. The Member missed a scheduled PCP appointment and one (1) documented attempt to reschedule have been unsuccessful. Documentation must demonstrate good faith effort to update the Member's contact information and attempts to perform the IHA at any subsequent office visits, even if the deadline for IHA completion has elapsed.

Monitoring and Oversight

A. IEHP monitors PCPs' compliance with IHA requirements through the Medical Record Review (MRR) survey process. The MRR verifies that an IHA was completed based on whether the record contains a comprehensive history and physical, and an IHEBA. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."

[9] DHCS PL 08-003
[10] Ibid.

B. As part of IEHP's oversight of IPA activities, quarterly IHA completion rates are reviewed and feedback is provided to the IPAs on their IHA completion rate.

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10. MEDICAL CARE STANDARDS

D. Obstetrical Services - PCP Role in Care of Pregnant Members

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs) providing care to IEHP DualChoice Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. PCPs are responsible for assessing whether a Member is pregnant, including the provision of pregnancy testing as appropriate.

PROCEDURES:

A. Once a Member is known to be pregnant, PCPs are responsible for determining whether the Member plans to continue the pregnancy or wishes to pursue a voluntary termination.

B. If the Member plans to continue the pregnancy, the PCP is responsible for referring the Member to an OB Practitioner, or giving the Member a choice of OB Practitioners, within the Member's IPA network. Otherwise, please see Policy 9D, "Access to Services with Special Arrangements" for information on termination of pregnancy.

C. For pregnant Members in prenatal care, PCPs are responsible for coordinating care with the OB Practitioner as necessary, including, but not limited to:
   1. Informing the OB Practitioner by phone or in writing of any significant medical conditions that may impact, or be impacted, by the pregnancy.
   2. Coordinating Member referrals with the OB Practitioner for any necessary specialty care needed for the Member; and
   3. Providing updates to the OB during the pregnancy of changes in the Member's medical status as needed.

D. PCPs cannot provide OB care for pregnant Members, unless specifically credentialed for OB privileges by IEHP and/or their IPA.
   1. All OB/GYN PCPs are credentialed for obstetrical services as part of the routine credentialing process unless they specifically request gynecologic privileges only.
   2. Family Practitioners wishing to provide obstetrical services must specifically request those privileges through IEHP or their IPA as outlined in Policy 5A1, "Credentialing Standards – Credentialing Policies."

10. MEDICAL CARE STANDARDS

D. Obstetrical Services - PCP Role in Care of Pregnant Members

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10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. All Providers of obstetrical (OB) services 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.[1] When applicable, Providers are required to also follow Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF).[2]

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. Participation in support services is voluntary and Members have the right to refuse any services offered.

PROCEDURES:

Identification of Pregnant Members

A. IEHP identifies Members who are pregnant through claims data, encounter data, pharmacy data, laboratory results, data collected through the utilization management or care management processes, authorizations, and referrals.

B. Providers are also responsible for assessing whether a Member is pregnant, including the provision of pregnancy testing as appropriate.

Access to Perinatal Services

A. Once the Primary Care Provider (PCP) or any other Specialist has established that the Member is pregnant, the Member may receive assistance from the PCP, their assigned IPA, or IEHP in scheduling an appointment for perinatal care.

B. IEHP and its IPAs must allow Members direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.[3] Basic perinatal 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.

C. Referrals for high-risk OB conditions, health education, nutrition, or psychosocial services are processed through the IPA's standard authorization process. Determinations must be made

[1] American Congress of Obstetrician and Gynecologists (ACOG), Guidelines for Perinatal Care, https://www.acog.org/clinical

[2] USPSTF Grade A and B Recommendations, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

[3] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)

timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14).[4] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

D. The initial prenatal visit must be scheduled to take place within two (2) weeks of the request. Urgent prenatal visits must be scheduled to take place within forty-eight (48) hours of the request.[5] Prenatal care should be initiated within the first trimester whenever possible.

E. Pregnant Members may receive perinatal care services from Certified Nurse Midwives (CNMs), Licensed Midwives (LMs) or Alternative Birthing Centers (ABCs) within or outside the Member's IPA or IEHP's network. Please see Policy 10D2, "Obstetrical Services – Obstetric Care by Certified Nurse Midwives, Licensed Midwives, and Alternative Birthing Centers."

Perinatal Care

A. The content and timing of perinatal care should be varied according to the needs and risk status of the woman and her fetus. Typically, a woman with an uncomplicated first pregnancy is examined every four (4) weeks for the first twenty-eight (28) weeks of pregnancy, every two (2) weeks until thirty-six (36) weeks of gestation, and weekly thereafter. Members with active medical or OB problems, as well as Members at the extremes of reproductive age, should be seen more frequently, at intervals determined by the nature and severity of the problems.[6]

B. During episodic or focused health care visits of Members who could become pregnant, in addition to performing a physical exam and obtaining her obstetric and gynecologic histories, the following core topics in pre-pregnancy should be addressed:[7]

1. Family planning and pregnancy spacing (see Policy 10K, "Family Planning Services");
2. Immunization status (see Policy 10B, "Adult Preventive Services");
3. Risk factors for sexually transmitted infections (see Policy 10G, "Sexually Transmitted Infection Services");
4. Substance use, including alcohol, tobacco, and recreational and illicit drugs;
5. Exposure to violence and intimate partner violence;
6. Medical, surgical, and psychiatric histories;
7. Current medications;

[4] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[5] Title 28, California Code of Regulations (CCR) § 1300.67.2.2(c)(5)(A)
[6] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[7] Ibid.

8. Family history;
9. Genetic history;
10. Nutrition, body weight, and exercise;
11. Teratogens, environmental and occupational exposures; and
12. Assessment of socioeconomic, education, and cultural context

C. Risk assessments must be performed during the initial prenatal visit, once each trimester thereafter and at the post-partum visit. Results from these assessments shall be maintained as part of the obstetrical record and include medical, obstetrical, nutritional, psychosocial, and health education needs risk assessment components (see Attachments, "ACOG Antepartum Record," "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).[8,9] If a Member refuses any or all risk assessments, a note documenting the attempt and refusal must be noted in the medical record.

D. The OB Practitioner must develop an individualized plan of care that is based on ongoing risk identification and assessment, as well as take into consideration the medical, nutritional, psychosocial, cultural, and educational needs of the Member. This plan of care must include obstetrical, nutrition, psychosocial, and health education interventions, and be periodically re-evaluated and revised in accordance with the progress of the pregnancy.[10,11]

E. All Members must receive a prescription for prenatal vitamins as a standard of care.[12]

F. Dental screening is considered 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.

Tobacco Prevention and Cessation

A. The USPSTF recommends that clinicians ask all pregnant people about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant people 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.

[8] 22 CCR § 51348(b)(1)
[9] Click here for the most current forms: https://www.acog.org/clinical-information/obstetric-patient-record-forms
[10] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[11] 22 CCR § 51348(b)(2)
[12] 22 CCR § 51348(c)(3)

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. The ACOG recommends clinical interventions and strategies for pregnant Members who use tobacco.[13]
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 International Classification of Diseases (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.

Genetic Screening

A. Information about the California Prenatal Screening Program must be offered to Members seen prior to the 20th week of pregnancy.
    1. The current services provide by the California Prenatal Screening Program may be found on the program's website: https://www.cdph.ca.gov/Programs/CFH/DGDS/pages/pns.
    2. Abnormal screening results are then followed up by State approved diagnosis centers (See Attachment, "California Prenatal Screening Program" in Section 10). Further diagnostic investigations must be coordinated by the prenatal care Provider as indicated.

B. Antenatal screening must be done whenever indicated to identify possible risks prior to pregnancy. Parents who have increased risks for pregnancies complicated by genetic abnormalities are referred to State approved Prenatal Diagnosis Centers for appropriate counseling. For the most current listing of State-approved Prenatal Diagnosis Center by County, go to http://cdph.ca.gov or call the Genetic Disease Branch, California Department of Health Care Services at (866) 718-7915.[14]

[13] The American Congress of Obstetricians and Gynecologists, "Committee Opinion Smoking Cessation During Pregnancy," Number 721, October 2017.

[14] https://www.cdph.ca.gov/Programs/CFH/DGDS/CDPH%20Document%20Library/PNS%20Documents/PDCs_by_County.pdf

High Risk Obstetrical Care

A. Pregnant Members at high risk of a poor pregnancy outcome must be referred to appropriate Specialists, including perinatologists and with proper referrals, have access to genetic screening.

Intrapartum Care

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

B. OB Practitioners must forward the Member's medical records to the delivery Hospital/birth facility 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. 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 IPA and Hospital/birth facility, coordinates referral of the newborn to the PCP within the mother's IPA 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 IPA's admitter panel for initial assessment of the newborn.

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

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

D. All Members should undergo a comprehensive postpartum visit within the first six (6) weeks after birth. This visit should include a full assessment of physical, social, and emotional well-being. The postpartum visit includes but is not limited to educating the Member on family planning, immunization, referral to a pediatric Practitioner for Well Child services and the Supplemental Food Program for Women, Infants and Children (WIC) program. Please see Policies 10E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)" and 10K, "Family Planning Services."

IEHP and IPA Responsibilities

A. IEHP informs Members of childbearing age of the availability of perinatal services, and how to access services through the Member Handbook, Member Newsletter, Member Services contacts, and Health Education programs. Members may also contact IEHP Member Services Department at (800) 440-4347 for information on perinatal services.

B. IEHP and its IPAs ensure that upon their request, current or newly enrolled Members with specified conditions can continue to obtain health care services from a Provider ending their contract with their IPA. This includes Members in the 2nd or 3rd trimesters of pregnancy and the immediate postpartum period, and newborn children between birth and age 36 months.[15] Please see Policy 12A5, "Care Management Requirements – Continuity of Care" for more information.

C. IEHP and its IPAs are responsible for coordinating referrals needed by the high-risk Member including, but not limited to: education and lifestyle change for gestational diabetics, perinatology, neonatologists, advanced OB and neonatal centers, transportation and durable medical equipment as appropriate.

D. The Member's IPA Case Management staff are responsible for assuring the coordination of all multi-disciplinary practitioners providing interventions for pregnant Members through transfer of medical records or intervention details, facilitation of necessary referrals and case conferences if necessary.

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[15] CA Health & Saf. Code § 1373.96

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

2. Obstetric Care by Certified Nurse Midwives, Licensed Midwives, and Alternative Birthing Centers

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Pregnant Members may receive perinatal care services from Certified Nurse Midwives (CNMs), Licensed Midwives (LMs) or Alternative Birthing Centers (ABCs) within or outside the Member's IPA or IEHP's network.

DEFINITIONS:

A. Alternative Birthing Center (ABC) – A health facility that is not a hospital and is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan.

PROCEDURES:

A. IEHP and its IPAs must allow women direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.[1,2]

B. Once pregnancy has been established by the Primary Care Provider (PCP) or another Provider, Members may access prenatal care from an Obstetrician, CNM, LM, or other qualified prenatal care Practitioner within or outside the Member's IPA network.

C. CNM and LM services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period.[3]

D. CNMs and LMs 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.

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[2] Department Health Care Services (DHCS) Policy Letter (PL) 12-003, "Obstetrical Care-Perinatal Services"
[3] Title 22, California Code of Regulations (CCR) § 51345

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

3. PCP Provision of Obstetric Care

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Primary Care Providers (PCPs) providing obstetrical (OB) care must meet the criteria established by IEHP, for participation in the network as an Obstetrics Provider, as set forth below.

PROCEDURES:

A. All PCP listed as a Family Practice 1 (FP1), Family Practice 2 (FP2), and Obstetrics and Gynecology, providing OB services to Members must meet the following criteria:

1. Education & Training. All practitioners must meet the education and training requirements for one (1) of the following specialties, set for forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).
    a. Family Practice, also applicable to:
        1) Family Practice 1: Family Practice Providers with OB Services
        2) Family Practice 2: Family Practice Providers that includes OB services and delivery
    b. Obstetrics and Gynecology
2. Hospital privileges. The Practitioner must have admitting privileges that include delivery, at an IEHP participating Hospital. For those Practitioners who do not hold their own admitting privileges that includes delivery, the following documentation must be provided for review:
    a. Family Practice 1 Providers must provide a signed a agreement that states Member transfers will take place within the first twenty (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
        1) The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that network.
    b. Family Practice 2 Providers must hold admitting privileges with delivery, at an IEHP participating Hospital and provide a written agreement for an available OB back up Provider is required.

1) The OB must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and

2) Provider a protocol for identifying and transferring high risk members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

c. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a PCP, will provide outpatient well woman services only with no Hospital or Surgical privileges, must provide the following information for consideration:

1) In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery (See Attachment, "Patient Transfer Agreement" in Section 5).

- The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
- The OB Provider within the same practice and must be credentialed and contracted within the same network.

2) These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Credentialing or Peer Review Subcommittee who will either approve or deny.

3. Facility Site Review. After submission of a request, IEHP staff schedules a site visit to determine if all facility criteria are met.

a. All PCPs must pass a required initial facility site review performed by IEHP prior to receiving IEHP enrollment and treating members.

b. IEHP provides written notice to requesting practitioners after the site visit either approving them, or not approving them with the reasons noted. Refer to Policy 6A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring" for more information.

1) PCPs denied participation due to quality of care can submit a written appeal to the IEHP Chief Medical Officer within thirty (30) days of the notification of the decision. (See Attachment, "IEHP Peer Review Level I and Credentialing Appeal" in Section 5).

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

3. PCP Provision of Obstetric Care

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10. MEDICAL CARE STANDARDS

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs, Primary Care Providers (PCP), Obstetrical (OB), and Pediatric Providers shall identify and refer eligible Members for Women, Infants and Children (WIC) services

PROCEDURES:

WIC Program

A. 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.

B. WIC participants must meet the following eligibility criteria:[1]

1. Income below 185% of the Federal Poverty Level; and
2. Pregnant person; or
3. Nursing a baby under one (1) year of age; or
4. Person who had a baby or was pregnant in the past six (6) months; or
5. A child up to their fifth birthday.

C. Members receive information regarding the availability of WIC Program services through the following methods:[2]

1. IEHP Member Handbook (upon health plan enrollment);
2. Providers;
3. IEHP Team Members; and
4. Health Plan Communications.

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

Referral

A. Each county WIC program can provide OBs, Pediatricians, and other PCPs with WIC

[1] https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HowCanIGetWIC.aspx
[2] Title 42 Code of Federal Regulations (CFR) § 431.635(c)(2)

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).

B. OBs, Pediatricians, and other PCPs assist Members in applying for WIC by providing them with WIC agency phone numbers and the required documentation, including:

1. Height and weight;
2. Results of hemoglobin and hematocrit laboratory tests;
3. Estimated date of delivery;
4. Growth assessment for infants and children; and
5. Any identified nutritional risk factors such as gestational diabetes.

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

C. The referring Provider must document the WIC referral and relevant laboratory values in the Member's medical record.

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

E. 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.

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

1. Riverside County - (800) 455-4942 or https://www.ruhealth.org/apply-4-wic
2. San Bernardino - (800) 472-2321 or https://wic.sbcounty.gov/doiqualify/
3. Out of County - (951) 360-8000

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10. MEDICAL CARE STANDARDS

F. Sterilization Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Sterilization is not a covered benefit under Medicare. Members that are IEHP DualChoice may be eligible for sterilization services through their IEHP Medi-Cal benefit.

B. IEHP ensures that obtaining and documenting informed consent for services, including sterilization, comply with State, Federal and contractual requirements.[1] See Policy 7C, "Informed Consent."

PROCEDURES:

A. Access to Sterilization Services

1. The IEHP DualChoice 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 (916) 650-0414 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.

B. Informed Consent

1. The Member must be at least 21 years of age at the time consent for sterilization is obtained, mentally competent to understand the nature of the proposed procedure and cannot be institutionalized.[2]
2. The PM 330 Sterilization Consent Form, which contains federal funding language, must be used, as mandated by the State of California (See Attachments, "PM 330 Sterilization

[1] Title 22, California Code of Regulations (CCR) § 51305.1 et seq.
[2] 22 CCR § 51305.1

Consent Form – English" and "PM 330 Sterilization Consent Form – Spanish" in Section 10).[3]

a. One (1) copy of the State of California approved booklets must be furnished to the Member, along with the consent forms.[4]

b. 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.

   1) The PM 330 Sterilization Consent Form must be signed by the Member after the discussion has taken place.[5] If an interpreter is used, he/she must also sign the consent form verifying his/her part in the discussion.[6] Suitable arrangements must be made to ensure that all necessary information is relayed to a Member who is visually impaired, deaf or otherwise a person with a disability.

   2) 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.[7]

   3) 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.[8] A copy of the consent form must be given to the Member.[9]

   4) A hysterectomy requires an additional consent form and is only covered when medically necessary. A hysterectomy is not compensated if performed or arranged solely to render the Member sterile.

   5) 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.[10] The consent must also have been signed seventy-two (72) hours prior to the Member having received any preoperative medication.[11]

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

   7) Original copies of the informed consent must be filed in the Member's medical

[3] 22 CCR § 51305.4
[4] 22 CCR § 51305.3
[5] 22 CCR § 51305.4
[6] Ibid.
[7] 22 CCR § 51305.3
[8] 22 CCR § 51305.1
[9] 22 CCR § 51305.3
[10] Ibid.
[11] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Sterilization"

record.

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10. MEDICAL CARE STANDARDS

G. Sexually Transmitted Infection Services

APPLIES TO:

A. A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP DualChoice Members have the right to seek treatment for sexually transmitted infections (STIs) from their Primary Care Providers (PCPs), the San Bernardino and Riverside County Local Health Department (LHD) clinics, qualified family planning Practitioners, or any other Practitioner, who treats STIs within their scope of practice. Services may be obtained from a Practitioner within or outside the IEHP network, without prior authorization.[1]

PROCEDURES:

A. IEHP, its IPAs and all Providers 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. 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, gonorrhea or other sexually transmitted infection, without examination of the Member's sexual partner or partners.[2]

C. IEHP DualChoice Members may make their own appointment with the STI services Practitioner of their choice. Members may call IEHP Member Services Department at (877) 273-4347 for assistance in accessing STI services. IEHP encourages Members to return to their PCPs to maintain continuity of care.

Access Within Network

A. Members may choose to receive STI services from any qualified Practitioner within the IEHP DualChoice network or their assigned IPA's network without prior authorization.[3]

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

Access Out-of-Network

A. Members may access STI services from an out-of-network qualified practitioner without prior authorization.[4]

B. Out-of-network practitioners may call IEHP Member Services Department at (877) 273-4347

[1] California Health and Safety Code (Health & Saf. Code) § 1367.31
[2] CA Health & Saf. Code § 120582
[3] CA Health & Saf. Code § 1367.31
[4] CA Health & Saf. Code § 1367.31

for DualChoice eligibility, benefits, benefit exclusions, limitations, and the name of the Member's IEHP PCP. IEHP encourages the out-of-network practitioner to refer the Member back to their PCP to maintain continuity of care.

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, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STI services Practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members (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). "Authorization for Use and Disclosure of Personal Health Information" forms can also be found on the IEHP website.

B. All Practitioners providing STI services are required by law to report individuals with certain communicable diseases to the Local Health Department (LHD). See Policy 10J, "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."

Coordination of Care

A. PCPs are responsible for coordinating care and avoiding duplicate service delivery and/or release of medical records for those Members that receive STI treatment outside of the network. 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 IEHP Direct or their IPA Case Management (CM) staff when Members have consented to release of information and require case management services due to their STI or medical condition complexity. IEHP or its IPA CM is then responsible for coordinating care including, but not limited to, referral to specialists and transfer of additional medical information.

Reimbursement

A. IEHP contracts define STI services as an IPA's responsibility. This responsibility includes payment for services accessed by IEHP DualChoice Members out-of-network.

B. STI treatment Practitioners providing services to non-assigned Members within the IEHP DualChoice network will follow IEHP DualChoice reimbursement guidelines.

10. MEDICAL CARE STANDARDS

G. Sexually Transmitted Infection Services

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10. MEDICAL CARE STANDARDS

H. HIV Testing and Counseling

APPLIES TO:

A. This policy applies to IEHP DualChoice Members.

POLICY:

A. IEHP requires Primary Care Providers (PCPs) to screen for HIV infection in alignment with recommendation from the United States Preventive Services Task Force (USPSTF).[1]

B. Members may access without prior authorization confidential HIV testing and counseling services within their IPA's network or through a Local Health Department (LHD) and family planning providers.[2,3]

PROCEDURES:

A. IEHP and Providers are required to follow all State laws governing consent for testing and disclosure of HIV test results, as well as the most up-to-date guidelines for HIV counseling, testing, treatment, and referral recommended by the U.S. Centers for Disease Control and Prevention (CDC).[4]

B. IEHP provides all 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).

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

Access to HIV Counseling and Testing Services

A. The assessment for HIV infection screening can occur in the following situations:

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.

B. The assessment performed by the PCP must align with the most up-to-date recommendations from the CDC.[5]

[1] United States Preventive Services Task Force (USPSTF), Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
[2] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"
[3] California Health and Safety Code (Health & Saf. Code) § 1367.46
[4] CDC HIV Testing Guidelines: https://www.cdc.gov/hiv/guidelines/testing.html.
[5] CDC HIV Screening in Clinical Settings: https://www.cdc.gov/hiv/clinicians/screening/clinical-settings.html

C. For those Members identified by the PCP as at risk for HIV infection, one (1) of the following must occur:

1. PCP provides HIV testing and counseling; or
2. 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.

D. PCPs are responsible for identifying Members who may potentially require care management services and notifying the IPA Care Management (CM) Department. PCPs may also submit a completed CM Referral Form to IEHP to refer the Member for care management. See Policy 12A1, "Case Management Requirements – PCP Role."

E. 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. See Policy 10K, "Family Planning Services";
2. As part of an STI visit at a LHD or other qualified Practitioner. See Policy 10G, "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.

F. IEHP Member Services is available to assist Members who request 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, Counseling and Follow-up for Pregnant Members

A. IEHP and IPA network Practitioners who provide perinatal care must comply with USPSTF HIV screening recommendations and state regulations, which require 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:[6,7]

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.

[6] California Health and Safety Code (Health & Saf. Code), § 125107
[7] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"

B. IEHP requires that all prenatal care Practitioners within its network and that of IPAs to 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.[8,9]

C. All IEHP and IPA prenatal care Practitioners are required to discuss with the Member:[10]

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

D. Practitioners must document in the Member's medical record that education, counseling, and testing was offered to the pregnant Member.[11]

Out-of-Network Reimbursement for Medicare 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.[12]

B. Out-of-network practitioners must submit claims to the Member's assigned 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. IEHP and its 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 16B4, "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 maintain patient confidentiality and privacy in alignment with states and federal regulations.[13] 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 the subject's written authorization.[14]

[8] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"
[9] USPSTF, Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
[10] DHCS PL 97-08
[11] Ibid.
[12] Ibid.
[13] CA Health & Saf. Code § 120975
[14] CA Health & Saf. Code § 120985

2. The Practitioner ordering the test may **not** disclose the results to IEHP, the Member's assigned IPA or any other health care service plan.[15,16]
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.[17] IEHP provides sample consent forms that may be used (See Attachments, "Consent for HIV Test – English" and "Consent for HIV Test – Spanish" in Section 10). These are also available online at www.iehp.org. Informed verbal consent is only sufficient when a treating Practitioner orders the test.

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,[18] all IEHP and IPA network Practitioners must obtain written consent from the Member to disclose HIV test results (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. See Policy 10J, "Reporting Communicable Diseases to Public Health Authorities."

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[15] CA Health & Saf. Code § 120985
[16] CA Health & Saf. Code § 121010
[17] CA Health & Saf. Code § 120990
[18] CA Health & Saf. Code § 12098

10. MEDICAL CARE STANDARDS

I. Tuberculosis Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Primary Care Providers (PCPs) must perform tuberculosis (TB) screening, diagnosis, treatment and follow-up as well as provide TB case and treatment in compliance with the most recent recommended guidelines from the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). [1,2,3,4]

DEFINITIONS:

A. Direct Observation Therapy (DOT) – A course of treatment, or preventive treatment, for Tuberculosis in which the prescribed course of medication is administered to the person or taken by the person under direct observation by a trained healthcare worker.[5]

PROCEDURES:

Provider Responsibilities

A. Risk Assessment

1. PCPs must assess Members for risk factors for developing TB at minimum during their initial health assessment. See Policy 10A, "Initial Health Assessment".
2. All IEHP Members with an increased risk of TB must be offered TB testing unless they have documentation of prior positive test results or TB disease.

B. Screening and Diagnosis

1. PCPs must initiate and perform diagnostic work-up for Members suspected of having active TB per the most recent CDC guidelines. [6]
2. All sputum specimens submitted for culture, including identification and sensitivity, must be directed to a laboratory, preferably a Local Health Department (LHD) laboratory. Laboratories must report to the LHD testing results, including molecular and pathologic

[1] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System (RUHS), Public Health Services, 06/01/14
[2] MOU between IEHP and San Bernardino County Department of Public Health (SBDPH), Health Services for Medi-Cal Members, 07/01/07
[3] https://www.thoracic.org/statements/tuberculosis-pneumonia.php
[4] https://www.cdc.gov/tb/publications/guidelines/default.htm
[5] https://www.cdc.gov/tb/programs/laws/menu/treatment.htm#observedTherapy
[6] https://www.cdc.gov/tb/publications/guidelines/default.htm

results, suggesting of diseases of public health importance. [7,8,9] See Policy 10J, "Reportable Communicable Diseases to Public Health Authorities."

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

3. 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.

C. Public Health Reporting

1. Providers must report all confirmed (TB3) or highly suspected (TB5) active TB cases to the LHD in the county where the Member resides.[10] See Policy 10J, "Reporting Communicable Diseases to Public Health Authorities" for reporting guidelines.

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

2. 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.[11]

3. PCPs must cooperate with LHD in conducting contact tracing and outbreak investigations potentially involving Members, as well as for any request for medical records, screening, diagnostic work-up, and any other pertinent clinical or administrative information. [12,13]

4. PCPs must provide appropriate examination and treatment to Members, identified by the LHD as contacts. These must be provided 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. [14,15]

5. 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.

D. Direct Observed Therapy (DOT)

1. The following groups of individuals are at risk for difficulty adhering to the treatment of TB. Providers shall refer Members with active TB and have any of these risks to the LHD:

[7] Title 17, California Code of Regulations (CCR) § 2505
[8] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[9] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07
[10] Title 17 California Code of Regulations (CCR) § 2500.
[11] California Health and Safety Code (Health & Saf. Code) § 121361.
[12] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[13] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07
[14] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[15] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07

a. Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);

b. Members whose treatment has failed or who have relapsed after completing a prior regimen;

c. Children and adolescents; and

d. Individuals who have demonstrated difficulty adhering to treatment (those who failed to keep office appointments).

2. Providers shall assess the following Members for consideration for DOT through the LHD:

   a. Substance users;

   b. Persons with mental illness;

   c. The elderly;

   d. Persons with unmet housing needs; and

   e. Persons with language and/or cultural barriers.

   If, in the opinion of the Provider, a Member with one (1) or more of these risk factors is at risk for difficulty adhering to treatment, the Provider must refer the Member to the LHD for DOT.

3. 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.

IEHP and IPA Responsibilities

A. IEHP and its IPAs provide monitoring and case management for all suspected and active TB cases. IEHP and IPA CM provide the coordination of TB care with the LHD. See policies 25C1, "Care Management Requirements –IEHP Monitoring and Oversight," and 25C1, "Care Management Requirements – IPA Responsibilities."

B. IEHP and its IPAs continue to provide all medically necessary covered services to Members with TB on DOT and ensures joint case management and coordination of care with the LHD.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

J. Reporting Communicable Diseases to Public Health Authorities

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Providers must report known and suspected cases of communicable disease to public health authorities in the county where the Member resides.[1]

PURPOSE:

A. To allow timely reporting to public health authorities to determine morbidity, evaluate transmission risk and intervene appropriately to minimize transmission.

PROCEDURES:

A. Providers must use the following guidelines to report a case or suspected case to the appropriate public health authority:

1. Extremely Urgent Conditions should be reported immediately by telephone, twenty-four (24) hours a day, to the after-hour emergency number listed in this policy (See Attachments, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" in Section 10). [2]

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]

3. All Other Non-Urgent Conditions may be reported by phone or mail on confidential morbidity report cards within seven (7) calendar days of identification (See Attachments, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" in Section 10).[4]

B. 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.[5] Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing the report:

[1] Title 17, California Code of Regulations (CCR) § 2500(b)
[2] 17 CCR § 2500(h)
[3] Ibid.
[4] Ibid.
[5] Ibid.

1. Riverside County - (951) 358-7327
2. San Bernardino County - (800) 472-5609

C. 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.

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

E. Local Health Departments (LHD) 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 the 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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

K. Family Planning Services

***APPLIES TO*:**

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP DualChoice Members have the right to access, without prior authorization, any qualified family planning Practitioner within or outside of the IEHP or the Member's IPA's network.

DEFINITIONS:

A. Family Planning Services - Services provided to individuals of child-bearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents.

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 a Member.

PROCEDURES:

Family Planning Services

A. According to IEHP's Division of Financial Responsibility (DOFR), professional services associated with family planning are the IPA's responsibility. This responsibility includes payment for services accessed by IEHP DualChoice Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. The following services may be provided to IEHP DualChoice Members as part of the family planning benefit:

1. Health education and counseling necessary to make informed choices and understand contraceptive methods;
2. History and physical examination limited to immediate problem;
3. Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods;
4. Diagnosis and treatment of Sexually Transmitted Infections (STIs);
5. Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment;
6. Follow-up care for complications associated with contraceptive methods issued by the family planning Provider;

7. 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 listed under the IEHP Formulary;
8. Tubal ligation;
9. Vasectomy; and
10. Pregnancy testing and counseling.

C. 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.

D. The following are not considered part of family planning services:

1. Facilitating services such as transportation, parking, and childcare while family planning care is being obtained;
2. Infertility studies or procedures provided for the purpose of diagnosis or treating infertility;
3. Reversal of voluntary sterilization;
4. Hysterectomy for sterilization purposes only;
5. Therapeutic abortions and related services; and
6. Spontaneous, missed, or septic abortions and related services.

E. A Physician, Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medication. A registered nurse who has completed required training may also dispense contraceptives when Evaluation and Management (E&M) procedure 99201, 99211, or 99212 is performed and billed with modifier 'TD.'

Freedom of Choice

A. Members must 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. IEHP DualChoice Members are informed upon enrollment that they have a right to access family planning services within and outside IEHP's network without prior authorization.

B. Members receive family planning and freedom of choice information from IEHP in the following ways:

1. Member Handbook;
2. Relevant IEHP Health Education programs and materials;
3. Member Newsletter; and
4. Member Services contacts.

Informed Consent

A. 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). If the Member is unable to give consent, their legal guardian must make appropriate care decisions as needed.

B. Practitioners are required to keep copies of signed informed consent forms in the Member's medical record as well as submit these with any claim forms.[1]

Accessing Family Planning Services

A. IEHP DualChoice 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 (916) 650-0414 to receive more information on qualified family planning Practitioners.

B. 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 Provider (PCP) for continuity and coordination of care.

C. 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, "Authorization or Refusal to Release Medical Record – Out-of-Network Family Planning – English" and "Authorization or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish" in Section 10).

D. 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 Member's 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).

Coordination of Care

A. Listed below are the roles and responsibilities of the PCP, out-of-network family planning Practitioner, the Member's IPA and IEHP staff in coordinating care for IEHP DualChoice Members accessing out-of-network practitioners for family planning.

   1. If a release is signed, and the Member needs care as a follow-up to the family planning

[1] Title 22, California Code of Regulations (CCR) § 51305.3

services or due to a complication of the family planning service, the out-of-network practitioner must contact the PCP or the Member's IPA Care Management (CM) department.

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., cervical cancer screening, 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, the Member's 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 the Member's IPA CM to coordinate care.

Out-of-Network Family Planning Services Reimbursement

A. 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.

B. Conditions for Reimbursement

1. 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.
2. 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.
3. IEHP and its IPAs must issue payment for family planning claims within thirty (30) business days of receiving the claim.
4. Family planning billing grievances are resolved in accordance with the Provider Grievance Process. See Policy 16B4, "Grievance and Appeal Resolution Process for Providers - IPA, Hospital, and Practitioner."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2011
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

L. Mandatory Elder or Dependent Adult Abuse Reporting

APPLIES TO:

A. This policy applies to Mandated Reporters who treat/or have contact with IEHP DualChoice Members.

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 practicably possible. An additional written report shall also be submitted to the appropriate agencies within two (2) working days.[1]

B. Mandated Reporters include, but are not limited to Primary Care Providers (PCPs), Specialists, nurses, and IEHP professional staff (i.e. Providers, 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 are NOT required to report incidents of Elder/Dependent Adult Abuse when **all** the following exist:[2]

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.

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 when 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,

[1] California Welfare and Institutions Code (Welf. & Inst. Code) § 15630(b)(1)
[2] CA Welf. & Inst. Code § 15630(b)(3)(A)

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 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 59 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.[3]

C. **Elder** – any person residing in this state, 59 years or older.[4]

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 Providers, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

[3] CA Welf. & Inst. Code § 15750(b)(1)(A)
[4] CA Welf. & Inst. Code § 15750(b)(2)

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.

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 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 PCPs, and other health care Providers 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**[5]

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 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

[5] CA Welf. & Inst. Code § 15630(b)(1)(A)

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**[6]

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**[7]

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 CA Welfare & Institutions Code § 15610.63.
   c. An assault with a deadly weapon[8] by a nonresident of the state mental hospital or state development center.
   d. An assault with force likely to produce great bodily injury.[9]
   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 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.

[6] CA Welf. & Inst. Code § 15630(b(1)(B)
[7] CA Welf. & Inst. Code § 15630(b)(1)€
[8] CA Penal Code § 245
[9] Ibid.

D. **Abuse Outside of a Long-Term Care Facility, State Mental Hospital, or a State Development Center**[10]

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.[11]

F. **Information to Include in Abuse Reports**

1. The report shall include the following, if known:[12]
   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.
   d. Nature and extent of the Elder/Dependent Adult's condition.
   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	**San Bernardino**
Dependent Adult and Elder Abuse: Adult Services Division (800) 491-7123 (24 hours)	Dependent Adult and Elder Abuse: Department of Aging and Adult Services (877) 565-2020 (24 hours)

[10] CA Welf. & Inst. Code § 15630
[11] CA Penal Code § 11161.8
[12] CA Welf. & Inst. Code § 15630

10. MEDICAL CARE STANDARDS

L. Mandatory Elder or Dependent Adult Abuse Reporting

Other Related Responsibilities

A. IEHP and its IPAs are responsible for educating their contracted PCPs and Specialists of the procedures for reporting Abuse cases.

B. IEHP and its IPAs are responsible for case managing abuse cases and verifying that reporting has occurred.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	April 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

M. Mandatory Domestic Violence Reporting

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Primary Care Providers (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 Providers who provide medical services are Mandated Reporters and as such they are responsible for directly informing the local law enforcement agency, within their respective county, of identified domestic violence cases. [1]

C. Mandated Reporters are health care Providers 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.[2]

D. Mandated Reporters will immediately make a report when they identify:[3]

   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.

   3. 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 regarding reporting domestic violence, which may be different from PCPs and other medical health care Providers.

[1] California Penal Code § 11160
[2] Ibid.
[3] Ibid.

10. MEDICAL CARE STANDARDS

M. Mandatory Domestic Violence Reporting

PROCEDURES:

Identification of domestic violence cases

A. At the health plan level, Providers, care managers, and UM personnel are able 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.
2. Mandated Reporters within IEHP have a variety of information sources for the identification of domestic violence cases including the following:
    a. Domestic violence cases identified during the utilization management or care management process;
    b. Requests for assistance received by Member Services from victims of domestic violence;
    c. Calls to the 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.[4]

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:[5]
    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.[6] The report consists of the Suspicious Injury Report (Form CalEMA-920).

[4] CA Penal Code § 11160
[5] Ibid.
[6] Ibid.

Riverside	**San Bernardino**
Riverside Sheriff's Dept.	San Bernardino Sheriff's Dept.
(951) 955-2526 or Call 911	(909) 884-0156 or Call 911

Other Related Responsibilities

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	April 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. Medical Care Standards

N. Maternal Mental Health Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice 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.[1]

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.[2]

PROCEDURES:

Identification of Members

A. IEHP Members to whom Providers must offer to screen or appropriately screen for maternal mental health conditions include 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 screening tools and practices recommended by Postpartum Support International (PSI), refer to the following website at: https://www.postpartum.net/professionals/screening/.

B. All IEHP Members are eligible for this program.

   1. Members can self-refer by calling Member Services at (877) 273-4347.
   2. IPAs and Providers can refer a Member by calling the Provider Relations Team at (909) 890-2054 or by submitting a Care Management Referral Form, which is available online at www.iehp.org.
   3. IEHP Team Members may refer to the Behavioral Health and Care Management (BH & CM) Department Members identified with potential need for maternal mental health services, who may be identified through health education programs and data analytics.

[1] California Health and Safety Code (Health & Saf. Code), § 123640
[2] Ibid.

10. Medical Care Standards

N. Maternal Mental Health Program

Program Enrollment

A. The BH & CM 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.

B. When a referral for maternal mental health services is received, IEHP reviews the Member's information on the medical management system and calls the Member.

C. 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. See Policy 12D1, "Behavioral Health – Behavioral Health Services" for more information.

D. 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.

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

O. Vision Examination Level Standards

APPLIES TO:

A. This policy applies to IEHP DualChoice Members.

POLICY:

A. IEHP's commitment to providing quality care to Members requires that certain tests be performed during comprehensive and intermediate ophthalmological exams.

PROCEDURES:

A. **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; and
4. Other diagnostic procedures as indicated and necessary.

B. 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. IEHP-credentialed Ophthalmology Providers should continue to work through their contracted IPA to provide these services.

C. 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 see Policy 12G, "Vision Services."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2012
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

10. MEDICAL CARE STANDARDS

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
ACOG Antepartum Record	10D1
Auth or Refusal to Release Medical Record - Out of Network Family Planning – English	7C, 10K
Auth or Refusal to Release Medical Record - Out of Network Family Planning – Spanish	7C, 10K
Authorization for Use and Disclosure of Personal Health Information - English	10G
Authorization for Use and Disclosure of Personal Health Information - Spanish	10G
California Prenatal Screening Program	10D1
Combined 2nd Trimester Reassessment	10D1
Combined 3rd Trimester Reassessment	10D1
Combined Post-Partum Reassessment	10D1
Consent for HIV Test – English	7C, 10H
Consent for HIV Test – Spanish	7C, 10H
Contraceptive Informed Choice Form – English	10K
Contraceptive Informed Choice Form – Spanish	10K
HIV Testing Sites – Riverside and San Bernardino	10H
Initial Perinatal Risk Assessment Form - English	10D1
Initial Perinatal Risk Assessment Form - Spanish	10D1
PM 330 Sterilization Consent Form – English	7C, 10F
PM 330 Sterilization Consent Form – Spanish	7C, 10F
Recommended Adult Immunization Schedule	10A, 10B
Reportable Diseases and Conditions – Riverside	10J, 10I
Reportable Diseases and Conditions – San Bernardino	10J, 10I
WIC Referral Forms	10E

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ANTEPARTUM RECORD

Date: – – ID #:

Hospital of Delivery:

Name:
LAST FIRST MIDDLE

Newborn Care Provider:	Referred By:
Primary Care Provider/Group:	Address:
Final EDD:	
Birth Date: Age: Race: Marital Status: S M W D Sep – –	Address: Zip: Phone: (1) (2)
Occupation: Education: (Last Grade Completed)	E-Mail:
Language: Ethnicity:	Insurance Carrier/Medicaid #:
Partner: Phone:	Policy #:
Father Of Baby: Phone:	Emergency Contact: Phone:

Total Preg:	Full Term:	Premature:	Ab, Induced:	Ab, Spontaneous:	Ectopic Pregnancy:	Multiple Births:	Living:

Menstrual History

Lmp ☐ Definite ☐ Approximate (Month Known) ☐ Unknown ☐ Normal Amount/Duration ☐ Final: _____

Duration: Q _____ Days

Prior Menses: _____ Date

Frequency: Q _____ Days

Contraception at pregnancy ☐ Yes ☐ No

Menarche: _____ (Age Onset)

Hcg + ___/___/___

Past Pregnancies (Last Five)

Date Month/ Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/ Complications

Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment
A. Drug/Latex Allergies/ Reactions	☐	☐	
B. Allergies (Food, Seasonal, Environmental)	☐	☐	
1. Neurologic/Epilepsy	☐	☐	
2. Thyroid Dysfunction	☐	☐	
3. Breast Disease/Breast Surgery	☐	☐	
4. Pulmonary (TB, Asthma)	☐	☐	
5. Heart Disease	☐	☐	
6. Hypertension	☐	☐	
7. Cancer	☐	☐	
8. Hematologic Disorders	☐	☐	
9. Anemia	☐	☐	
10. Gastrointestinal Disorders	☐	☐	
11. Hepatitis/Liver Disease	☐	☐	
12. Kidney Disease/UTI	☐	☐	
13. Deep Vein Thrombosis	☐	☐	
14. Diabetes (Type 1 Or Type 2)	☐	☐	
15. Gestational Diabetes	☐	☐	
16. Autoimmune Disorders	☐	☐	
17. Dermatologic Disorders	☐	☐	
18. Operations/Hospitalizations (Year & Reason)	☐	☐	
19. Gyn Surgery (Year & Reason)	☐	☐	
20. Anesthetic Complications	☐	☐	
21. History Of Blood Transfusions	☐	☐	
22. Infertility	☐	☐	
23. Art (IVF Or FET)	☐	☐	
24. History of Abnormal Pap	☐	☐	
25. History of STI	☐	☐	
26. Psychiatric Illness	☐	☐	
27. Depression/Postpartum Depression	☐	☐	
28. Trauma/Violence	☐	☐	
29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)	☐	☐	
30. Alcohol (AMT/Wk)	☐	☐	
31. Drug Use (Including Opioids) (Uses/Wk)	☐	☐	
32. Polycystic Ovary Syndrome	☐	☐	
33. Other	☐	☐	

Prepreg	Preg	# Years Use

*P= Personal, F= Family

COMMENTS: _____

ANTEPARTUM RECORD (FORM A, page 1 of 12)

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Genetic Screening*

Condition	Patient	Partner	Other	Relationship
Congenital Heart Defect				
Neural Tube Defect				
Hemoglobinopathy Or Carrier				
Cystic Fibrosis				
Chromosome Abnormality				
Tay–Sachs				
Hemophilia				
Intellectual Disability/Autism				
Recurrent Pregnancy Loss/Stillbirth				
Other Structural Birth Defect				
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)				

Teratogen Exposures Since LMP/Pregnancy

	Yes	No	Details/Date
Prescription Medications			
Over The Counter Medications			
Alcohol			
Illicit Drugs			
Maternal Diabetes			HGB A1C
Other			
Uterine Anomaly/DES			

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

Infection History

	Yes	No
1. Live with Someone with TB or Exposed to TB		
2. Patient or Partner Has History of Genital Herpes		
3. Rash or Viral Illness Since Last Menstrual Period		
4. Prior GBS-Infected Child		
5. History of STIs: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID		

	Yes	No
6. HIV Infection		
7. History Of Hepatitis		
8. Recent Travel History or Partner Travel Outside of Country		
9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.		
10. Other (See Comments)		

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible)			
Influenza† (Each pregnancy as soon as vaccine is available)			
Varicella†			
MMR (Rubella-containing vaccine)†			
HPV			

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Hepatitis A (When Indicated)			
Hepatitis B (When Indicated)			
Meningococcal (When Indicated)			
Pneumococcal (When Indicated)			

*Yes/No and date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Initial Physical Examination

Date: _____ / _____ / _____ BP/Prepregnancy Weight: _____ Height: _____ BMI: _____

1. Heent	☐	Normal	☐	Abnormal	11. Vulva	☐	Normal	☐	Condyloma	☐ Lesions
2. Teeth	☐	Normal	☐	Abnormal	12. Vagina	☐	Normal	☐	Inflammation	☐ Discharge
3. Thyroid	☐	Normal	☐	Abnormal	13. Cervix	☐	Normal	☐	Inflammation	☐ Lesions
4. Breasts	☐	Normal	☐	Abnormal	14. Uterus Size		Weeks			☐ Fibroids
5. Lungs	☐	Normal	☐	Abnormal	15. Adnexa	☐	Normal	☐	Mass	
6. Heart	☐	Normal	☐	Abnormal	16. Rectum	☐	Normal	☐	Abnormal	
7. Abdomen	☐	Normal	☐	Abnormal	17. Clinical Pelvimetry	☐	Concerns	☐	No Concerns	
8. Extremities	☐	Normal	☐	Abnormal						
9. Skin	☐	Normal	☐	Abnormal						
10. Lymph Nodes	☐	Normal	☐	Abnormal						

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Drug Allergy:_____ Latex Allergy ☐ Yes ☐ No Postpartum Contraception Method:_____
Counseled About LARC? ☐ Yes ☐ No

Is Blood Transfusion Acceptable? ☐ Yes ☐ No Antepartum Anesthesia Consult Planned ☐ Yes ☐ No

Problems	Plans	Resolved?
1.		
2.		
3.		
4.		
5.		

Medication List (Including Opioids)	Start Date	Stop Date
1.	– –	– –
2.	– –	– –
3.	– –	– –
4.	– –	– –
5.	– –	– –

EDD Confirmation								Pregnancy Weight Gain	
Lmp:	– –	=		= EDD	– –			Prepregnancy Weight	
Initial Exam:	– –	=		Wks = EDD	– –			Height	
Ultrasonography:	– –	=		Wks = EDD	– –			BMI	
Final EDD:	– –			IVF Transfer:	– –			Estimated Weight Gain	
Initialed By:								Recommended Weight Gain	

Prepregnancy Weight

_____

BMI

_____

Date	Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale * (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: *=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	Comments:
– –																
– –																
– –																
– –																
– –																
– –																
– –																
– –																
– –																
– –																
– –																
– –																

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

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Laboratory and Screening Tests*

Initial Labs	Date	Result	Reviewed
Blood Type	– –	A ☐ B ☐ AB ☐ O ☐	
D (Rh) Type	– –		
Antibody Screen	– –		
Complete Blood Count	– –	HCT/HGB: _____ % _____ g/dL MCV:_____ PLT:_____	
VDRL/RPR (Syphilis)	– –		
Urine Culture/Screen	– –		
HBsAg	– –		
HIV Testing	– –	Pos. ☐ Neg. ☐ Declined ☐	
Chlamydia	– –		
Gonorrhea (When Indicated)	– –		
Rubella Immunity	– –		
Other:			

Supplemental Labs	Date	Result	
Hemoglobin Electrophoresis	– –	AA ☐ AS ☐ SS ☐ AC ☐	
PPD/Quanta (When Indicated)	– –		
Pap Test (When Indicated)	– –		
HPV (When Indicated)	– –		
Early Diabetes Screen (When Indicated)	– –	Pos. ☐ Neg. ☐ Declined ☐	
Varicella Immunity (When Indicated)	– –		
Cystic Fibrosis	– –	Pos. ☐ Neg. ☐ Declined ☐	
Spinal Muscular Atrophy	– –	Pos. ☐ Neg. ☐ Declined ☐	
Fragile X	– –	Pos. ☐ Neg. ☐ Declined ☐	
Tay–Sachs	– –	Pos. ☐ Neg. ☐ Declined ☐	
Canavan Disease	– –	Pos. ☐ Neg. ☐ Declined ☐	
Familial Dysautonomia	– –	Pos. ☐ Neg. ☐ Declined ☐	
Genetic Screening Tests (See Form B)	– –	Pos. ☐ Neg. ☐ Declined ☐	
Zika Virus (When Indicated, All Trimesters)†	– –		
Other:			

8–20-Week Aneuploidy Screening	Date Test Performed	Result
Aneuploidy Screening Offered	– –	Accepted ☐ Declined ☐ GA Too Advanced ☐
1st Trimester Aneuploidy Screening	– –	Pos ☐ Neg ☐
2nd Trimester Serum Screening	– –	Pos ☐ Neg ☐
Integrated Screening	– –	Pos ☐ Neg ☐
Cell-Free DNA	– –	Pos ☐ Neg ☐
CVS	– –	Karyotype: 46,XX Or 46,XY/Other_____ Array
Amniocentesis	– –	Karyotype: 46,XX Or 46,XY/Other_____ Array
Amniotic Fluid (AFP)	– –	Normal ☐ Abnormal ☐
Other:		

Comments/Additional Labs

(continued)

*For serologic test results, rubella status, hepatitis B results, HIV status, GBS, Zika, and other maternal test results that are relevant to neonatal care, please attach lab results
†Check cdc.gov/zika for updates.

PROVIDER SIGNATURE (AS REQUIRED): _____

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Laboratory and Screening Tests *(continued)*

Late Pregnancy Labs and Screening	Date	Result	Reviewed
Complete Blood Count	– –	HCT/HGB:_____ % _____ g/dL MCV:_____ PLT:_____	
Diabetes Screen (24–28 Weeks)	– –		
GTT (If Screen Abnormal)	– –	☐ Fbs ☐ 1 Hour ☐ 2 Hours ☐ 3 Hours	
D (Rh) Antibody Screen (When Indicated)	– –		
Anti-D Immune Globulin (RhIg) Given (28 Wks Or Greater) (When Indicated)	– –	_____ Signature	
Ultrasonography (18–24 Weeks) (When Indicated)	– –		
HIV (When Indicated)‡	– –		
VDRL/RPR (Syphilis) (When Indicated)	– –		
Gonorrhea (When Indicated)	– –		
Chlamydia (When Indicated)	– –		
Group B Strep (35–37 Weeks)	– –		
Resistance Testing If Penicillin Allergic	– –		
Other:			

Comments/Additional Labs

‡Check state requirements before recording results.

Comments

PROVIDER SIGNATURE (AS REQUIRED): _____

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Plans/Education/Screening

By Trimester. Initial And Date When Discussed.

	NA	Date	Follow-Up Needed	Referral	Comments
First Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling*		– –			
Psychosocial Screening					
Desire For Pregnancy		– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)		– –			
Alcohol		– –			
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)		– –			
Illicit/Recreational Drugs/Substance Use (Parents, Partner, Past, Present)†		– –			
Intimate Partner Violence		– –			
Barriers To Care		– –			
Unstable Housing		– –			
Communication Barriers		– –			
Nutrition		– –			
Wic Referral					
Environmental/Work Hazards		– –			
Anticipatory Guidance					
Anticipated Course Of Prenatal Care		– –			
Nutrition Counseling; Special Diet; Dietary Precautions (Mercury, Listeriosis)		– –			
Weight Gain Counseling		– –			
Toxoplasmosis Precautions (Cats/Raw Meat)		– –			
Use Of Any Medications (Including Supplements, Vitamins, Herbs, Or Otc Drugs)		– –			
Sexual Activity		– –			
Exercise		– –			
Dental Care/Refer to Dentist		– –			
Avoidance Of Saunas Or Hot Tubs		– –			
Seat Belt Use		– –			
Childbirth Classes/Hospital Facilities		– –			
Breastfeeding		– –			
Fetal Testing					
Indications For Ultrasonography		– –			
Screening For Aneuploidy		– –			
Second Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling†		– –			
Anticipatory Guidance					
Signs And Symptoms Of Preterm Labor		– –			
Selecting A Newborn Care Provider		– –			
Reproductive Life Planning & Contraception		– –			
Postpartum Care Planning		– –			
Psychosocial Screening					
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)		– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)		– –			
Intimate Partner Violence		– –			

*Check cdc.gov/zika for updates.

†Data from Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990.

(continued)

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Plans/Education/Screening *(continued)*

By Trimester. Initial and Date When Discussed.

	NA	Date	Follow-Up Needed	Referral	Comments
Third Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling†	☐	– –			
Birth Preferences					
Pain Management Plans	☐	– –			
Trial Of Labor After Cesarean Counseling	☐	– –			☐ TOLAC ☐ Elective RCS
Labor Support Person(s)	☐	– –			
Immediate Postpartum LARC	☐	– –			☐ Implant ☐ LNG-IUS ☐ Copper IUD
Circumcision Preference	☐	– –			☐ Yes ☐ No
Infant Feeding Intention	☐	– –			☐ Exclusive ☐ Mixed ☐ Formula
Anticipatory Guidance					
Fetal Movement Monitoring	☐	– –			
Signs And Symptoms Of Preeclampsia	☐	– –			
Labor Signs	☐	– –			
Cervical Ripening/Labor Induction Counseling	☐	– –			
Postterm Counseling	☐	– –			
Infant Feeding	☐	– –			
Newborn Education (Newborn Screening, Immunizations, Jaundice, SIDS/Safe Sleeping Position, Car Seat)	☐	– –			
Family Medical Leave Or Disability Forms	☐	– –			
Postpartum Depression	☐	– –			
Psychosocial Screening					
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)	☐	– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)	☐	– –			
Intimate Partner Violence	☐	– –			
Postpartum					
Screening					
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)	☐	– –			
Infant Feeding Problems	☐	– –			
Birth Experience	☐	– –			
Glucose Screen (If GDM)	☐	– –			
Zika Assessment, Testing (When Indicated), And Counseling†	☐	– –			
Anticipatory Guidance	☐				
Infant Feeding	☐	– –			
Pelvic Muscle Exercise/Kegel	☐	– –			
Return To Work / Milk Expression	☐	– –			
Weight Retention	☐	– –			
Optimal Birth Spacing	☐	– –			
Postpartum Sexuality	☐	– –			
Exercise	☐	– –			
Nutrition	☐	– –			
Cardiometabolic Risk (If GDM/Gestational Hypertension)	☐	– –			
Transition Of Care					
Referral Made To Primary Care Provider	☐	– –			
Pregnancy Complications Documented In Medical Record	☐	– –			
Written Recommendations For Follow-Up Communicated To Patient And To PCP	☐	– –			

†Check cdc.gov/zika for updates.

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Plans/Education/Screening *(continued)*

By Trimester. Initial and Date When Discussed.

Requests

	Date	Initials	
Tubal Sterilization Consent Signed (If Desired).	– –		
History And Physical Have Been Sent To Hospital, If Applicable.	– –		
Update With Group B Streptococcus Results Sent.	– –		
Update With HIV Results Sent.	– –		
Update With Zika Results Sent.	– –		
Update With Hepatitis B Results Sent.	– –		
Update With Rubella Results Sent.	– –		
Update With Other Maternal Results Sent (Specify).	– –		

Comments

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

PLANS/EDUCATION/SCREENING NOTES

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Name:
LAST FIRST MIDDLE

ID#: EDD:

Prenatal Visits

Prepregnancy Weight

BMI

Date

Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale* (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: +=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	**Comments:**
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*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

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Name:
LAST FIRST MIDDLE

ID#: EDD:

Prenatal Visits

Prepregnancy Weight

BMI

Date	Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale * (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: +=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	**Comments:**
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Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

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Patient Name:		Birth Date: – –	ID No.:	Date: – –

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

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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
(nombre de la clínica)

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 _____ (fecha) a _____ (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.*

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

Table of Contents

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.

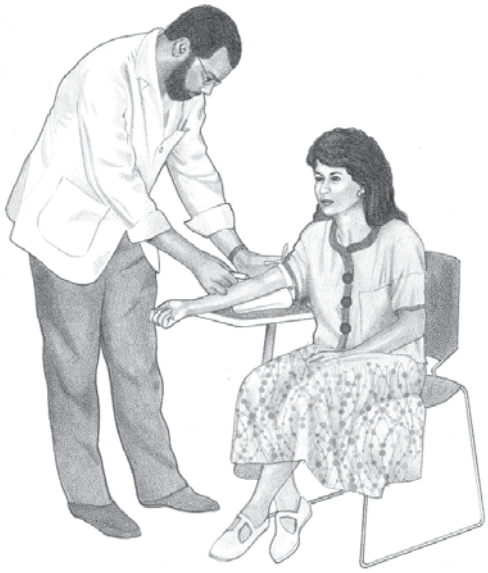
Blood Tests are Part of Prenatal Screening

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)

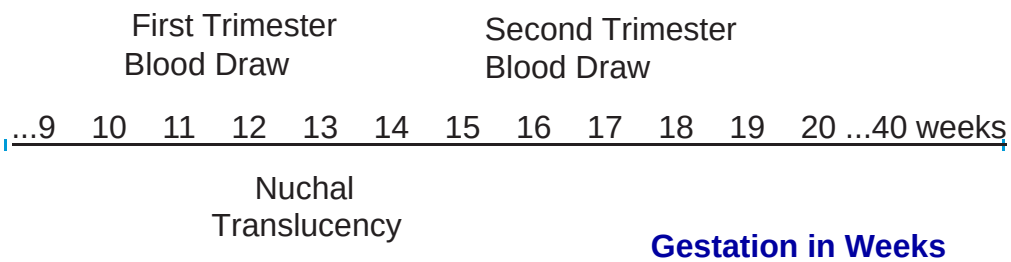
These substances are made by the pregnant woman and her unborn baby. At each week of pregnancy, there are different expected amounts of these substances in the mother's blood. Other information used for the screening test includes age, race and weight.

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



The California Prenatal Screening Program Offers Three Types of Screening Tests

Sequential Integrated Screening

First Trimester Risk Assessment

A fi rst 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 fluidatthe back of the baby's neck. All babies have a collection of fluid,butbabies 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.

Comparing The Three Types of Prenatal Screening Tests

Name of Screening Test	Test Type	When the Test is Done	Detection Rates
Sequential Integrated Screening	**Two Blood Draws + Nuchal Translucency Ultrasound**	First blood draw between 10 weeks to 13 weeks 6 days of pregnancy. Nuchal Translucency ultrasound 11 weeks 2 days to 14 weeks 2 days Second blood draw between 15 to 20 weeks of pregnancy.	90 out of 100 **Down syndrome** 81 out of 100 **Trisomy 18** ❖❖❖❖❖❖❖❖❖❖❖❖❖ 97 out of 100 **anencephaly** 80 out of 100 **open spina bifida** 85 out of 100 **abdominal wall defects** 60 out of 100 **SLOS**
Serum Integrated Screening	**Two Blood Draws**	First blood draw between 10 weeks to 13 weeks 6 days of pregnancy. Second blood draw between 15 to 20 weeks of pregnancy.	85 out of 100 **Down syndrome** 79 out of 100 **Trisomy 18** ❖❖❖❖❖❖❖❖❖❖❖❖❖ 97 out of 100 **anencephaly** 80 out of 100 **open spina bifida** 85 out of 100 **abdominal wall defects** 60 out of 100 **SLOS**
Quad Marker Screening	**One Blood Draw**	Between 15 to 20 weeks of pregnancy	80 out of 100 **Down syndrome** 67 out of 100 **Trisomy 18** ❖❖❖❖❖❖❖❖❖❖❖❖❖ 97 out of 100 **anencephaly** 80 out of 100 **open spina bifida** 85 out of 100 **abdominal wall defects** 60 out of 100 **SLOS**

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.

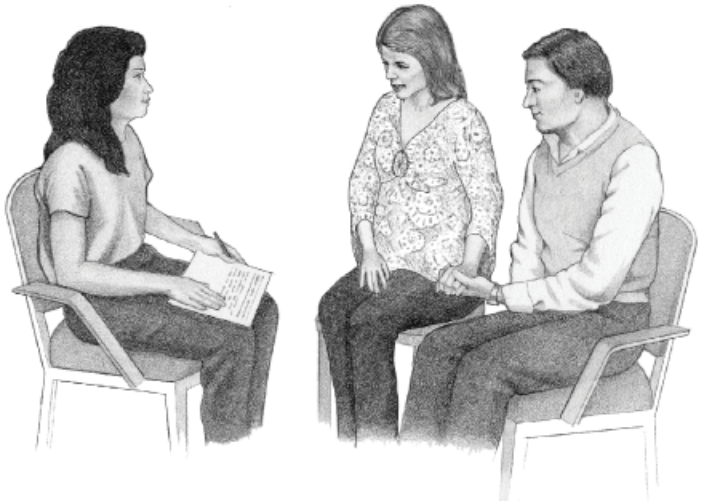
Test Results and Follow-Up Services

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 firstserviceawomanreceivesat 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,Trisomy18 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 **D**emise (fetal death).
That is why this screening is also called S**CD** 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 specificbirth 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.

CLINICIAN COPY
MUST BE FILED IN PATIENT CHART

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.

Clinician Copy **Page 2**

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_____

PATIENT COPY

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 re search 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_____

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 work place, 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

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; 866-767-6227
- National Marrow Donor Program:
  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 offi ce 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

Th e 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.
Th e 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.

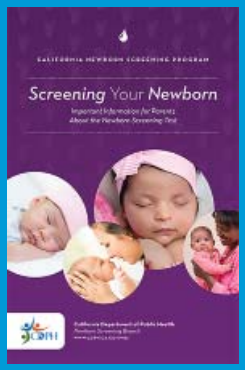
Other genetic diseases - Cystic Fibrosis, Severe Combined Immunodeficiency (SCID), Adrenoleukodystrophy (ALD).

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

Member Name_____ **DOB**_____ **EDC**_____ **Date**_____

ANTHROPOMETRIC ☐ **WT. GRID PLOTTED**
Wt. this visit: Weeks Gestation:
Gain Since Last Visit: Total Wt. Gain:
Comment:

BIOCHEMICAL

Blood	**Date Collected:**		
Hemoglobin:	**H L**	Hematocrit:	**H L**
MCV:	**H L**	Albumin:	**H L**
Glucose:	**H L**	GTT:	**H L**

Urine	**Date Collected:**		
Glucose:	+ -	Protein:	+ -
Ketones:	+ -		

CURRENT CLINICAL
Blood Pressure: Edema:
1. Scheduled test or procedures? **Y N**
   If **YES**, please list.
2. Taking prenatal vitamins? **Y N**
   Iron? **Y N**
3. Taking new medications or herbs? **Y N**
   If **YES**, please list?
4. Significant changes since last assessment? **Y N**
   If **YES**, please explain.

Clinical Update from previous visit:

NUTRITION
5. Have your eating habits changed since your last assessment? **Y N**
   If **YES**, please explain

Dietary Assessment ☐ **24 hour recall completed**
Dietary Goals/Comments:

Infant Feeding
6. How do you plan to feed your baby?
☐ Breast ☐ Bottle ☐ Both ☐ Not Sure
7. Have you breastfed a baby before? Y N
   If **YES**, how long did you breastfeed?_____

HEALTH EDUCATION
8. Do you have an infant car seat? **Y N**
9. Do you have a doctor for the baby? **Y N**
10. Do you know what birth control you will use? **Y N**
11. Have you receive counseling on HIV (AIDS)? **Y N**

Substance Abuse:
12. Are you smoking at all? **Y N**
    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?
_____

Labor and Delivery
15. Have you had a hospital tour ☐ Y ☐ N
16. Do you need information about what will happen during labor and delivery? ☐ Y ☐ N

Health Education Goals:

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? Y N
22. Are you able to pay your rent? Y N
23. Are you able to pay your other bills? Y N
24. How do you feel about this pregnancy? _____
25. Since becoming pregnant, have you had? (✓ if yes)
☐ trouble sleeping ☐ sadness ☐ worried feelings
☐ crying ☐ depression ☐ sadness ☐ none
☐ other_____
26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes, by whom?_____

REFERRALS:
☐ WIC Date enrolled _____
Appointment Date _____
☐ Car Seat Class Date Attended _____

Other referrals 1) _____ Date _____
2) _____ Date _____

MATERIALS GIVEN:
☐ Family Planning ☐ Infant Feeding
☐ Other _____ ☐ 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

Member Name_____ DOB_____ EDC_____ Date_____

ANTHROPOMETRIC ☐ **WT. GRID PLOTTED**
Wt. this visit: Weeks Gestation:
Gain Since Last Visit: Total Wt. Gain:
Comment:

BIOCHEMICAL

Blood	**Date Collected:**		
Hemoglobin:	**H L**	Hematocrit:	**H L**
MCV:	**H L**	Albumin:	**H L**
Glucose:	**H L**	GTT:	**H L**

Urine	**Date Collected:**		
Glucose:	+ -	Protein:	+ -
Ketones:	+ -		

CURRENT CLINICAL
Blood Pressure: Edema:
1. Scheduled test or procedures? **Y N**
   If **YES**, please list.
2. Taking prenatal vitamins? **Y N**
   Iron? **Y N**
3. Taking new medications or herbs? **Y N**
   If **YES**, please list?
4. Significant changes since last assessment? **Y N**
   If **YES**, please explain.

Clinical Update from previous visit:

NUTRITION
5. Have your eating habits changed since your last assessment? **Y N**
   If **YES**, please explain

Dietary Assessment ☐ **24 hour recall completed**
Dietary Goals/Comments:

Infant Feeding
6. How do you plan to feed your baby?
☐ Breast ☐ Bottle ☐ Both ☐ Not Sure
7. Have you breastfed a baby before? Y N
   If **YES**, how long did you breastfeed?_____

HEALTH EDUCATION
8. Do you have an infant car seat? **Y N**
9. Do you have a doctor for the baby? **Y N**
10. Do you know what birth control you will use? **Y N**
11. Have you receive counseling on HIV (AIDS)? **Y N**

Substance Abuse:
12. Are you smoking at all? **Y N**
    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?
_____

Labor and Delivery
15. Have you had a hospital tour ☐ Y ☐ N
16. Do you need information about what will happen during labor and delivery? ☐ Y ☐ N

Health Education Goals:

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? Y N
22. Are you able to pay your rent? Y N
23. Are you able to pay your other bills? Y N
24. How do you feel about this pregnancy? _____
25. Since becoming pregnant, have you had? (✓ if yes)
☐ trouble sleeping ☐ sadness ☐ worried feelings
☐ crying ☐ depression ☐ sadness ☐ none
☐ other_____
26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes, by whom?_____

REFERRALS:
☐ WIC Date enrolled _____
Appointment Date _____
☐ Car Seat Class Date Attended _____

Other referrals 1) _____ Date _____

2) _____ Date _____

MATERIALS GIVEN:
☐ Family Planning ☐ Infant Feeding
☐ Other _____ ☐ Other _____

ASSESSMENT SUMMARY:

Reviewed By:

Next Assessment Date:_____

For Provider Use Only

IEHP Member Number:_____

Prenatal Care Provider:_____

IEHP Provider Number:_____

INLAND EMPIRE HEALTH PLAN
COMBINED POST-PARTUM ASSESSMENT

Member Name_____ **DOB**_____ **Delivery Date** _____ **Date**_____

ANTHROPOMETRIC ☐ **WT. GRID PLOTTED**
Height _____ Desirable Body Weight_____
Weight this Visit _____ Weeks Post-Partum_____

BIOCHEMICAL
Blood **Date Collected:**
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:

Maternal
1. Have you had your post-partum check up? ☐ Y ☐ N
   If NO, when is it scheduled? _____
2. Have you had any problems since delivery: ☐ Y ☐ N
   If YES, please explain.

Infant
3. Has your baby seen the doctor? ☐ Y ☐ N
   If NO, when is a visit scheduled?

NUTRITION
Dietary Assessment ☐ **24 hour recall completed**
4. Are you on a special diet? ☐ Y ☐ N
   If YES, what diet? _____
5. Are you allergic to any foods, or do you avoid eating any foods? ☐ Y ☐ N
   If YES, what foods?_____
6. Which of the following do you take:
   ☐ Prenatal Vitamins ☐ Iron Pills
   ☐ Other Vitamins/Minerals ☐ Herbs
   ☐ Antacids ☐ Laxatives ☐ Other Medications
7. How many cups, glasses, or cans of these do you drink daily? Water _____ Milk _____
   Juice _____ Coffee _____
   Tea _____ Soda _____
   Diet Soda _____ Punch/Kool Aid _____
8. How many times a day do you usually eat? _____
9. Which of the following do you have?
   ☐ Refrigerator ☐ Stove/Oven ☐ Hot Plate

Infant Feeding
10. How many diapers does your baby wet in a day? _____
11. If you are Breastfeeding:
    a) how many times in 24 hours do you nurse? _____
    b) how long does your baby nurse each time? _____

Infant Feeding (cont)
12. 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
    d) what else do you give your baby? ☐ Juice ☐ Cereal
       ☐ Sugar Water ☐ Baby Food ☐ Other _____

HEALTH EDUCATION
13) Do you have any questions about your baby's care? ☐ Y ☐ N
    If YES, please explain:
14) Which method of Birth Control are you currently using:
    ☐ Birth Control Pills ☐ Diaphragm ☐ Condoms
    ☐ Norplant ☐ Depo-Provera(shots) ☐ Other _____
15) Would you like more information about Birth Control?
16) Do you have an infant safety seat? ☐ Y ☐ N
    If YES, do you always use it?_____
17) Do you exercise 3 or more times a week? ☐ Y ☐ N
18) Do you smoke ? ☐ Y ☐ N
    If YES, how many cigarettes per day? _____
19) Do you live with someone who smokes?
20) How often do you drink beer, wine, or liquor? _____
21) What drugs have you used since the birth of your baby?

PSYCHOSOCIAL
22) Since your baby's birth, which of the following have you had?
    ☐ trouble sleeping ☐ sadness ☐ worried feelings
    ☐ crying ☐ depression ☐ sadness ☐ none
    ☐ other_____
23) If you are worried about something, who do you talk to?
    _____
24) Are you and your baby are safe in your home? ☐ Y ☐ N
25) Have you ever planned or tried to hurt yourself? ☐ Y ☐ N
26) Have you ever planned or tried to hurt someone? ☐ Y ☐ N
27) Since the birth of your baby, have you been slapped, hit, kicked or otherwise physically hurt by someone? ☐ Y ☐ N
    If YES, by whom? _____
28) Do you have: ☐ electricity ☐ hot water ☐ telephone
    ☐ transportation ☐ heating
29) Are you able to buy enough food? ☐ Y ☐ N
30) Are you able to pay your rent? ☐ Y ☐ N
31) Are you able to pay your other bills? ☐ Y ☐ N

☐ WIC Referral Date enrolled _____
Appointment Date _____
Other Referrals**:**
1) _____ Date _____
2) _____ Date _____
Materials Given**:**
☐ Family Planning ☐ Infant Feeding
☐ Other _____ ☐ Other _____

For Provider Use Only
Prenatal Care Provider:_____ **IEHP Member Number:**_____
IEHP Provider Number:_____

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.

CONSENTIMIENTO PARA EL ANÁLISIS DE VIH

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) ó compañero(s) que comparta(n) 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, confirmo 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, confirmo 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.

Inland Empire Health Plan

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%
Contraceptive Injection	99%
Female Condom	79-95%
Fertility Awareness	80-98%
IUD (Intrauterine Device)	99%
Male Condom	88-98%
Natural Family Planning	80-98%
Subdermal Contraceptive Implant	99%
Spermicides (Foam, Suppositories, Vaginal Film)	79-94%
Sterilization for Men or Women	99%
Vaginal Contraceptive Ring)	99%
Transdermal Contraceptive 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 _____.

Signed _____

Date _____

Witness _____

Date _____

Clinic _____

Phone _____

Inland Empire Health Plan

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 Anticonceptive	99%
Condon Femenino	79-95%
Conocimientos sobre Fertilidad	80-98%
Dispositivo Intrauterino (Aparato)	99%
Condon Masculino	88-98%
Planificacion Natural de la Familia	80-98%
Implante Anticonceptivo Subdérmico	99%
Espermicidas (Espuma, Supositorios, Film Vaginal)	79-94%
Esterilizacion para el Hombre o la Mujer	99%
Anillo Anticonceptivo Vaginal	99%
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 cuándo, donde y como conseguir ayuda médica.

Basada en la comprensión y entendimiento que tengo de lo mencionado arriba, he decidido usar _____ _____.

Firma _____

Fecha _____

Testigo _____

Fecha _____

Clinica _____

Telefóno _____

IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)

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 Avenue
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

INLAND EMPIRE HEALTH PLAN

HIV TESTING SITES - SAN BERNARDINO COUNTY

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) /
Thur (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

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

DATE_____ MEMBER NAME_____

AGE_____ EDC: _____ IEHP MEMBER NUMBER_____

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)
(Note: Complete Diet Recall at this time if not already completed.)

Please answer the following questions by marking a √ in the ☐or by writing in the blank space

STATUS

1. What languages do you speak? ☐ English ☐ Spanish Other_____ — 1. ☐L ☐ M ☐ H
2. What languages do you read? ☐ English ☐ Spanish Other_____ — 2. ☐L ☐ M ☐ H
3. How many years of school have you finished? _____years — 3. ☐L ☐ M ☐ H
4. Do you have a job? ☐ Yes ☐ No What kind of work?_____ — 4. ☐L ☐ M ☐ H
5. Does your partner have a job? ☐ Yes ☐ No What kind of work?_____ — 5. ☐L ☐ M ☐ H
6. Are you on a special diet? ☐ Yes ☐ No If you are on a special diet, what kind? — 6. ☐L ☐ M ☐ H
   Weight loss ☐ low fat /low cholesterol ☐ low salt ☐ diabetic
   Other_____
7. Are you a vegetarian? ☐ Yes ☐ No — 7. ☐L ☐M ☐ H
   If yes, do you use milk products (milk, cheese, yogurt) and /or eggs? ☐ Yes ☐ No
8. Are you allergic to any foods, or do you try not to eat any foods?
   ☐ Yes ☐ No If yes, what_____ — 8. ☐L ☐M ☐ H
9. How many cups, glasses or cans of these do you drink every day? — 9. ☐L ☐M ☐ H
   water_____ milk_____ juice_____ diet soda_____ punch/kool aid_____
   coffee____ tea_____ soda_____
10. How many times a day do you usually eat (including snacks)?_____ — 10. ☐L ☐M ☐ H
11. Do you have — 11. ☐L ☐M ☐ H
    - nausea ☐ Yes ☐ No How often?_____
    - vomiting ☐ Yes ☐ No How often?_____
    - poor appetite ☐ Yes ☐ No How often?_____
    - weight loss ☐ Yes ☐ No How many pounds?_____
    - diarrhea ☐ Yes ☐ No How often?_____
    - constipation ☐ Yes ☐ No How often?_____
    - heartburn ☐ Yes ☐ No How often?_____
    - ☐ other _____
12. What home remedies, food supplements, or herbs are you taking? — 12. ☐L ☐M ☐ H
    - Ginseng ☐ Yes ☐ No How often?_____
    - Ma Huang (Ephedra) ☐ Yes ☐ No How often?_____
    - Manzanilla (Chamomile) ☐ Yes ☐ No How often?_____
    - Hierba buena (Peppermint)☐ Yes ☐ No How often?_____
    - ☐ other _____
13. During this pregnancy, have you eaten — 13. ☐L ☐M ☐ H
    - maicena (cornstarch) ☐ Yes ☐ No How often?_____
    - laundry starch ☐ Yes ☐ No How often?_____
    - dirt or clay ☐ Yes ☐ No How often?_____
    - paste or plaster ☐ Yes ☐ No How often?_____
    - freezer frost ☐ Yes ☐ No How often?_____
    - ☐ other _____
14. During this pregnancy, are you taking — 14. ☐L ☐M ☐ H
    - aspirin ☐ Yes ☐ No How often?_____
    - cold medicine ☐ Yes ☐ No How often?_____
    - allergy/sinus medicine ☐ Yes ☐ No How often?_____
    - diet pills ☐ Yes ☐ No How often?_____
    - prenatal vitamins ☐ Yes ☐ No How often?_____
    - other vitamins ☐ Yes ☐ No How often?_____
    - iron pills ☐ Yes ☐ No How often?_____
    - ☐ other _____

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT
PROVIDER INFORMATION:

Provider Name:_____ IEHP Provider Number:_____

STATUS

15. How do you plan to feed your new baby? ☐ Breast ☐ Bottle ☐ Both ☐ not sure — 15. ☐ L ☐ M ☐ H
16. Have you breastfed a baby before? ☐ Yes ☐ No — 16. ☐ L ☐ M ☐ H
17. a. Where are you living right now? ☐ House ☐ Apartment ☐ Motel
☐ in a friend's house or apartment ☐ Car ☐ Street ☐ other_____ — 17. ☐ L ☐ M ☐ H
How long have you lived there?_____

18. How many people live with you? — 18. ☐ L ☐ M ☐ H
☐ no one ☐ 1-3 others ☐ 4-6 others ☐ 7 or more others
Who lives with you?
☐ live alone ☐ husband/partner ☐ parents ☐ in-laws
☐ your children ☐ other's children ☐ friends ☐ other family
How many children are in your household?_____

19. If you are worried about something, who do you talk to ? — 19. ☐ L ☐ M ☐ H
☐ partner/husband ☐ parents ☐ grandparents ☐ other relatives
☐ friend ☐ other person_____

20. Do you have (√☐if yes) — 20. ☐ L ☐ M ☐ H
☐ electricity ☐ hot water ☐ refrigerator ☐ stove or oven
☐ transportation ☐ telephone ☐ heating

21. Are you usually able to (√☐if yes) — 21. ☐ L ☐ M ☐ H
☐ buy enough food ☐ pay rent ☐ pay other bills

22. Have you ever had trouble finding a doctor, or getting medical help for yourself or your family? ☐ Yes ☐ No — 22. ☐ L ☐ M ☐ H
If yes, please explain_____

23. Are you on the WIC (Women, Infants & Children) Program? ☐ Yes ☐ No — 23. ☐ L ☐ M ☐ H
24. Do you have an infant car seat? ☐ Yes ☐ No — 24. ☐ L ☐ M ☐ H
25. Do you use you car seat belt? ☐ Yes ☐ No — 25. ☐ L ☐ M ☐ H
26. Was your pregnancy planned? ☐ Yes ☐ No — 26. ☐ L ☐ M ☐ H
27. How does the baby's father feel about this pregnancy? — 27. ☐ L ☐ M ☐ H
☐ doesn't care ☐ doesn't know ☐ angry ☐ happy ☐ sad ☐ other_____
28. How do you feel about this pregnancy? — 28. ☐ L ☐ M ☐ H
☐ don't care ☐ angry ☐ happy ☐ sad ☐ other_____
29. Have you ever had any of the following? — 29. ☐ L ☐ M ☐ H
☐ Miscarriage ☐ abortion ☐ stillbirth ☐ fetal demise
☐ neonatal death ☐ premature birth ☐ none
When did it happen?_____

What/who helped you get through this?_____

30. Do you have any traditional, cultural, or religious customs about pregnancy or childbirth you would like supported? ☐ Yes ☐ No — 30. ☐ L ☐ M ☐ H

31. Since becoming pregnant, which of the following have you had? (√☐if yes) — 31. ☐ L ☐ M ☐ H
☐ problem sleeping ☐ excessive worrying ☐ crying ☐ depression
☐ sadness ☐ none ☐ other_____

32. Are you taking medicine for your nerves?
☐ Yes ☐ No Name of Medicine_____ — 32. ☐ L ☐ M ☐ H

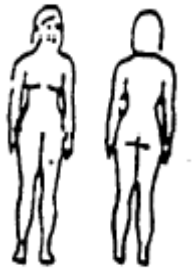
33. What two problems in your life cause you the most trouble? — 33. ☐ L ☐ M ☐ H
1. _____ 2._____

34. Have you ever thought about, planned, or tried to hurt yourself? ☐ Yes ☐ No — 34. ☐ L ☐ M ☐ H

35. Have you ever thought about, planned, or tried to hurt someone else? ☐ Yes ☐ No — 35. ☐ L ☐ M ☐ H

36. In the past year, have you been slapped, hit, kicked, or otherwise physically hurt be someone? — 36. ☐ L ☐ M ☐ H
☐ Yes ☐ No
By whom? (Check all that apply)
☐ partner/husband ☐ ex-husband ☐ parent
☐ step-parent ☐ stranger ☐ brother/sister
☐ other_____ # times hurt_____

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT



STATUS

37. On this picture mark the area of the body where you have been hurt. — 37. ☐ L ☐ M ☐

38 .For how many months or years have you been hurt by this person?_____ — 38. ☐ L ☐ M ☐ H
☐ Not applicable

39. How many cigarettes do you smoke each day? — 39. ☐ L ☐ M ☐ H
☐ don't smoke ☐ less than ½ pack ☐ ½ pack ☐ ½ to 1 pack
☐ 1-2 packs ☐ 2-3 packs more than 3 packs

40. Do you live with anyone who smokes? ☐ Yes ☐ No — 40. ☐ L ☐ M ☐ H

41. Check all that apply:
a. Does the father of your baby use drugs or drink alcohol? ☐ Yes ☐ No — 41a. ☐ L ☐ M ☐ H
Do/did your parents use drugs or drink alcohol? ☐ Yes ☐ No
Do/did you have friends who use drugs or drink alcohol? ☐ Yes ☐ No
b. What drugs did you use before this pregnancy? — 41b. ☐ L ☐ M ☐ H
☐ cocaine ☐ marijuana ☐ speed, methamphetamines ☐ PCP
☐ heroin ☐ none ☐ other_____
c. How often do you drink beer, wine, or liquor? — 41c. ☐ L ☐ M ☐ H
☐ daily ☐ weekends ☐ 1-2 times a month ☐ rarely or never
Have your alcohol habits changed since you became pregnant?
☐ Yes ☐ No If yes, how?_____

42. Have you received counseling on HIV (AIDS) in pregnancy? ☐ Yes ☐ No — 42. ☐ L ☐ M ☐ H

43. Tell us what you know about and want to learn about: — 43. ☐ L ☐ M ☐ H

Already Know	Like to Know		Already Know	Like to 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) — 44a. ☐ L ☐ M ☐ H
_____read _____watch video _____talk one-to-one
_____go to class _____Pictures or diagrams _____Demonstration
Other _____
b. Do you have any problems with hearing, seeing, or depression that will make it hard for you to learn new things? ☐ Yes ☐ No — 44b. ☐ L ☐ M ☐ H
If yes, please explain_____

45. a. Will you have any problems coming to prenatal classes? ☐ Yes ☐ No — 45a. ☐ L ☐ M ☐ H
☐ H If yes, please explain_____
b. Who can come to prenatal classes with you?_____ — 45b. ☐ L ☐ M ☐ H
things (goals) you would like to work on during this pregnancy.

46. List one or two things (goals) you would like to work on during this pregnancy — 46. ☐ L ☐ M ☐ H
1. _____
2. _____

If patient assisted by staff to complete assessment tool
Assessment Tool Completed by:

INLAND EMPIRE HEALTH PLAN
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

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

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. **STATUS**

1. ¿Qué idiomas habla usted? ☐ inglés ☐ español otros _____ — 1. ☐L ☐M ☐H
2. ¿Qué idiomas lee usted? ☐ inglés ☐ español otros _____ — 2. ☐L ☐M ☐H
3. ¿Cuántos años de escuela ha completado? _____ años — 3. ☐L ☐M ☐H
4. ¿Tiene usted un trabajo? ☐ sí ☐ no ¿Qué tipo de trabajo? _____ — 4. ☐L ☐M ☐H
5. ¿Tiene trabajo su pareja? ☐ sí ☐ no ¿Qué tipo de trabajo? _____ — 5. ☐L ☐M ☐H
6. ¿Está usted llevando una dieta especial? ☐ sí ☐ no Si contestó "sí", ¿indique qué tipo de dieta especial? — 6. ☐L ☐M ☐H
   ☐ para bajar de peso ☐ baja en grasa/colesterol ☐ baja en sal ☐ para diabéticos
   ☐ otra _____
7. ¿Es usted vegetariana? ☐ sí ☐ no — 7. ☐L ☐M ☐H
   Si contestó "sí", ¿consume usted productos lácteos (queso, leche, yogurt) y/o huevos? ☐ sí ☐ no
8. ¿Es usted alérgica a algún alimento o existe algún alimento que evite comer? ☐ sí ☐ no — 8. ☐L ☐M ☐H
   Si contestó "sí", ¿cuáles son esos alimentos? _____
9. ¿Cuántas tazas, vasos o latas de los siguientes líquidos bebe usted diariamente? — 9. ☐L ☐M ☐H
   agua _____ leche _____ jugo _____ soda de dieta _____
   refresco/"kool aid" _____ café _____ té _____ soda _____
10. ¿Cuántas veces al día come usted generalmente (incluyendo bocadillos)? _____ — 10. ☐L ☐M ☐H
11. Tiene usted: — 11. ☐L ☐M ☐H
    - náusea ☐ sí ☐ no ¿Con qué frecuencia? _____
    - vómito ☐ sí ☐ no ¿Con qué frecuencia? _____
    - mal apetito ☐ sí ☐ no ¿Con qué frecuencia? _____
    - pérdida de peso ☐ sí ☐ no ¿Cuántas libras? _____
    - diarrhea ☐ sí ☐ no ¿Con qué frecuencia? _____
    - estreñimiento ☐ sí ☐ no ¿Con qué frecuencia? _____
    - acidez estomacal ☐ sí ☐ no ¿Con qué frecuencia? _____
    - ☐ otro _____
12. ¿Qué remedios caseros, suplementos alimenticios y hierbas está usted tomando? — 12. ☐L ☐M ☐H
    - Ginseng/ ginsén ☐ sí ☐ no ¿Con qué frecuencia? _____
    - Ma Huang/ belcho (ephedra) ☐ sí ☐ no ¿Con qué frecuencia? _____
    - Manzanilla (camomile) ☐ sí ☐ no ¿Con qué frecuencia? _____
    - Hierbabuena (mint) ☐ sí ☐ no ¿Con qué frecuencia? _____
    - ☐ otro _____
13. Durante este embarazo, ¿ha comido usted lo siguiente? — 13. ☐L ☐M ☐H
    - maicena (cornstarch) ☐ sí ☐ no ¿Con qué frecuencia? _____
    - almidón ☐ sí ☐ no ¿Con qué frecuencia? _____
    - tierra o barro ☐ sí ☐ no ¿Con qué frecuencia? _____
    - engrudo o yeso ☐ sí ☐ no ¿Con qué frecuencia? _____
    - escarcha del congelador ☐ sí ☐ no ¿Con qué frecuencia? _____
    - ☐ otro_____
14. Durante este embarazo, ¿está usted tomando lo siguiente? — 14. ☐L ☐M ☐H
    - aspirina ☐ sí ☐ no ¿Con qué frecuencia? _____
    - medicinas para resfriados/ catarros ☐ sí ☐ no ¿Con qué frecuencia? _____
    - medicinas para alergias/ sinusitis ☐ sí ☐ no ¿Con qué frecuencia? _____
    - pastillas de dieta ☐ sí ☐ no ¿Con qué frecuencia? _____
    - vitaminas prenatales ☐ sí ☐ no ¿Con qué frecuencia? _____
    - otras vitaminas ☐ sí ☐ no ¿Con qué frecuencia? _____
    - pastillas de hierro ☐ sí ☐ no ¿Con qué frecuencia? _____
    - ☐ otro_____

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT
PROVIDER INFORMATION:

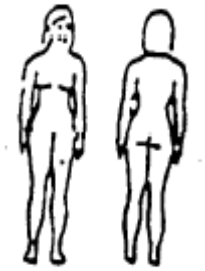
Provider Name:_____ IEHP Provider Number:_____

STATUS

15. ¿Cómo planea usted alimentar a su nuevo bebé? ☐ pecho ☐ biberón ☐ambos ☐ no estoy segura — 15. ☐L ☐M ☐H
16. ¿Ha amamantado usted antes a un bebé? ☐ sí ☐ no — 16. ☐L ☐M ☐H
    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 — 17. ☐L ☐M ☐H
    b. ¿Por cuánto tiempo ha vivido allí? _____
18. ¿Cuántas personas viven con usted? ☐ nadie ☐ 1-3 personas ☐ 4-6 personas ☐ 7 o más personas — 18. ☐L ☐M ☐H
    ¿Quién vive con usted?
    ☐ vivo sola ☐ esposo/pareja ☐ padres ☐ suegros
    ☐ mis hijos ☐ hijos ajenos ☐ amigos(as) ☐ otros familiares
    ¿Cuántos niños viven en su casa? _____
19. Cuando le preocupa algo, ¿con quién habla usted? ☐ esposo/pareja ☐ padres ☐ abuelos ☐ otros familiares ☐ amiga(o) ☐ otra persona _____ — 19. ☐L ☐M ☐H
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 — 20. ☐L ☐M ☐H
21. Generalmente, ¿puede usted hacer lo siguiente? (Indique con una √ en el ☐ si su respuesta es "sí") ☐ comprar suficiente comida ☐ pagar el alquiler ☐ pagar otras cuentas — 21. 21. ☐L ☐M ☐H
22. ¿Ha tenido usted alguna vez problemas buscando un doctor o consiguiendo ayuda médica para usted o su familia? ☐ sí ☐ no — 22. ☐L ☐M ☐H
    Si contestó "sí", favor de explicar: _____
23. ¿Está usted inscrita en el programa WIC (programa para mujeres, infantes y niños)? ☐ sí ☐ no — 23. ☐L ☐M ☐H
24. ¿Tiene usted un asiento de seguridad para su bebé? ☐ sí ☐ no — 24. ☐L ☐M ☐H
25. ¿Usa usted los cinturones de seguridad de su carro? ☐ sí ☐ no — 25. ☐L ☐M ☐H
26. ¿Fue este embarazo planeado? ☐ sí ☐ no — 26. ☐L ☐M ☐H
27. ¿Cómo se siente el padre del bebé sobre este embarazo? ☐ no le importa ☐ no sabe ☐ molesto ☐ feliz ☐ triste ☐ otro _____ — 27. ☐L ☐M ☐H
28. ¿Cómo se siente usted sobre este embarazo? ☐ no me importa ☐ molesta ☐ feliz ☐ triste ☐ otro _____ — 28. ☐L ☐M ☐H
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
    ¿Cuándo sucedió? _____
    ¿Qué/quién la ayudó a afrontar esta situación? _____ — 29. ☐L ☐M ☐H
30. ¿Tiene usted alguna costumbre tradicional, cultural o religiosa sobre el embarazo o el parto que quisiera que respetemos? ☐ sí ☐ no
    Si contestó "sí", por favor explique: _____ — 30. ☐L ☐M ☐H
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 _____ — 31. ☐L ☐M ☐H
32. ¿Está usted tomando medicina para los nervios? ☐ sí ☐ no Nombre de la medicina: _____ — 32. ☐L ☐M ☐H
33. ¿Cuáles son los dos problemas en su vida que más le preocupan?
    1. _____ 2. _____ — 33. ☐L ☐M ☐H
34. ¿Ha pensado, planeado o tratado usted alguna vez de hacerse daño? ☐ sí ☐ no — 34. ☐L ☐M ☐H
35. ¿Ha pensado, planeado o tratado usted alguna vez de hacerle daño a alguien más? ☐ sí ☐ no — 35. ☐L ☐M ☐H
36. Durante el transcurso del último año, ¿ha sido usted abofeteada, golpeada, pateada o lastimada fisicamente 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 _____ — 36. ☐L ☐M ☐H

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

STATUS



37. Indique en este dibujo el área del cuerpo donde usted ha sido lastimada: 37. ☐L ☐M ☐H

38. ¿Por cuántos meses o años la ha lastimado a usted esta persona?_____ 38. ☐L ☐M ☐H

39. ¿Cuántos cigarrillos fuma usted por día? 39. ☐L ☐M ☐H
☐ no fumo ☐ menos de 1/2 cajetilla ☐ 1/2 cajetilla ☐ 1/2 - 1 cajetilla
☐ 1-2 cajetillas ☐ 2-3 cajetillas ☐ más de 3 cajetillas

40. ¿Vive usted con alguien que fuma? ☐ sí ☐ no 40. ☐L ☐M ☐H

41. Marque todas las respuestas que correspondan:

a. ¿Usa el padre de su bebé drogas o bebidas alcohólicas? ☐ sí ☐ no 41a.☐L ☐M☐H
¿Usan/usaron sus padres drogas o bebidas alcohólicas? ☐ sí ☐ no
¿Tiene/tuvo amigos que usan drogras o bebidas alcohólicas? ☐ sí ☐ no

b. ¿Cuáles drogras usó usted antes de este embarazo? 41b.☐L ☐M ☐H
☐ cocaína ☐ marihuana ☐ metanfetaminas (speed) ☐ PCP ☐ heroína
☐ ninguna ☐ otra _____

c. ¿Con qué frecuencia toma usted cerveza, vino, or licor? 41c.☐L ☐M ☐H
☐ 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 42. ☐L ☐M ☐H

43. Díganos sobre que temas usted ya sabe y sobre cuales le gustaría saber: 43. ☐L ☐M ☐H

Ya sé	Me gustaría saber		Ya sé	Me gustaría saber	
☐	☐	El cuidado de un niño	☐	☐	Amamantando a un bebé
☐	☐	Recorrido del hospital	☐	☐	Alimentación infantil
☐	☐	El parto	☐	☐	El cuidado de un bebé
☐	☐	Abuso sexual	☐	☐	Ejercicio
☐	☐	Circuncisión	☐	☐	Dejando de fumar
☐	☐	Abuso de substancias	☐	☐	Violencia en el hogar
☐	☐	El crecimiento de un bebé	☐	☐	Enfermedades transmitidas sexualmente
☐	☐	Guiando al niño en su comportamiento	☐	☐	Cambios del cuerpo durante el embarazo
	☐	Otra _____			
☐	☐	Asiento de seguridad			
☐	☐	Señales de un parto prematuro			

44. a. ¿De qué manera aprende usted mejor algo nuevo? (Marque todos las respuestas que correspondan) 44a.☐L ☐M ☐H
☐ leyendo ☐ mirando un video ☐ hablando cara a cara ☐ yendo a clase
☐ dibujos o diagramas ☐ demostración ☐ otra _____

b. ¿Tiene usted algun problema de depresión, para oír, o para ver lo cual dificultaría el que pueda aprender cosas nuevas? ☐ sí ☐ no 44b.☐L ☐M ☐H
Si contestó "sí", favor de explicar: _____

45. a. ¿Va ha tener usted algún problema para venir a las clases prenatales? ☐ sí ☐ no 45a.☐L ☐M ☐H
Si contestó "sí", favor de explicar: _____

b. ¿Quién le puede acompañar a las clases prenatales? _____ 45b.☐L ☐M ☐H

46. Escriba una o dos cosas (metas) sobre las que quisiera enfocarse durante este embarazo? 46. ☐L ☐M ☐H
1. _____
2. _____

If patient assisted by staff to complete assessment tool

INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

Assessment Tool Completed by:

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 _____

Copy Permission:
Riverside/San Bernardino County DOPH-CPSP Program

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Attachment 10 - PM 330 Sterilization Consent Form - English

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

_____ . When I first asked for
(doctor or clinic)

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 HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

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

_____ .
(Name of procedure)

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 withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____ .
Mo Day Yr

I, _____
Last

_____ _____
First *M. I.*

hereby consent of my own free will to be sterilized by

_____ by a
(Doctor's name)

method called _____ .
(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
(Name of Individual to be sterilized)

consent form, I explained to him/her the nature of the sterilization

operation _____, the fact that it
(Name of procedure)

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 anytime 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.

_____ *Date:* ____/____/____
Signature of person obtaining consent *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

_____ on
(Name of individual to be sterilized)

____/____/____ *(Date of Sterilization),* I explained to him/her the nature of the
Mo Day Yr

sterilization operation _____ ,
(Name of procedure)

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. In those cases, the second paragraph below must be used. **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 ☐ Premature delivery date: ____/____/____ Individual's **expected date**
Mo Day Yr

of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B ☐ Emergency abdominal surgery; describe circumstances: _____

_____

_____ *Date:* ____/____/____
Signature of Physician performing surgery *Mo Day Yr*

State of California -- Health and Human Services Agency

CONSENT FORM - PM 330

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de _____ (doctor o clinica). 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 se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

_____ (Nombre del procedimiento)

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 médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____. *Mes Día Año*

Apellido

Nombre *I.*

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por _____ (Nombre del Doctor)

utilizando un método conocido como _____ (Nombre del procedimiento)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

_____ *Fecha:* ____/____/____

Firma de la persona a se esterilizada *Mes Día Año*

■ 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.

_____ *Fecha:* ____/____/____

Firma del intérprete *Mes Día Año*

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que _____ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como _____ (Nombre del procedimiento). 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 le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

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.

_____ *Fecha:* ____/____/____

Firma de quien recibe el consentimiento *Mes Día Año*

_____

Nombre del lugar donde el paciente recibió la información

_____

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a _____ (Nombre de la persona a ser esterilizada) en ____/____/____ (Fecha de esterilización), le explique la naturaleza del metodo de esterilizacion conocido como _____ (Nombre del procedimiento), también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Mes Día Año

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

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.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A ☐ Fecha de parto prematuro: ____/____/____ **Fecha anticipada** del parto: ____/____/____ (Debe ser 30 dias a partir de la firma de la persona).

Mes Día Año

B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: ____

_____

_____ *Fecha:* ____/____/____

Firma del Doctor a cargo de la cirugía *Mes Día Año*

Recommended Adult Immunization Schedule
for ages 19 years or older

UNITED STATES
2022

How to use the adult immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Assess need for additional recommended vaccinations by medical condition or other indication **(Table 2)**

3 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

4 Review contraindications and precautions for vaccine types **(Appendix)**

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Haemophilus influenzae type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Heplisav-B®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 15-valent conjugate vaccine	PCV15	Vaxneuvance™
Pneumococcal 20-valent conjugate vaccine	PCV20	Prevnar 20™
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), and American Academy of Physician Associates (www.aapa.org), and Society for Healthcare Epidemiology of America (www.shea-online.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims

All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation.

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- Travel vaccine recommendations: www.cdc.gov/travel
- Recommended Child and Adolescent Immunization Schedule, United States, 2022: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Scan QR code for access to online schedule

CS310021-A

Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2022

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV4) or **Influenza recombinant** (RIV4)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			1 dose PCV15 followed by PPSV23 OR 1 dose PCV20
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition or Other Indication, United States, 2022

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 percentage and count		Asplenia, complement deficiencies	End-stage renal disease, or on hemodialysis	Heart or lung disease; alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
			<15% or <200 mm³	≥15% and ≥200 mm³							
IIV4 or RIV4	1 dose annually										
or										or	
LAIV4	Contraindicated						Precaution			1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Contraindicated*	Contraindicated		1 or 2 doses depending on indication							
VAR	Contraindicated*	Contraindicated			2 doses						
RZV		2 doses at age ≥19 years			2 doses at age ≥50 years						
HPV	Not Recommended*	3 doses through age 26 years			2 or 3 doses through age 26 years depending on age at initial vaccination or condition						
Pneumococcal (PCV15, PCV20, PPSV23)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)									
HepA					2 or 3 doses depending on vaccine						
HepB	3 doses (see notes)	2, 3, or 4 doses depending on vaccine or condition									
MenACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	Precaution	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT[3] recipients only			1 dose						

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination for adults with an additional risk factor or another indication
- Recommended vaccination based on shared clinical decision-making
- Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended—vaccine should not be administered.

*Vaccinate after pregnancy.

- No recommendation/ Not applicable

1. Precaution for LAIV4 does not apply to alcoholism. **2.** See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. **3.** Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2022

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child and Adolescent Immunization Schedule.

COVID-19 Vaccination

COVID-19 vaccines are recommended within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html.

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Haemophilus influenzae type b vaccination

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**
  - **Persons experiencing homelessness**
  - **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
  - **Travel in countries with high or intermediate endemic hepatitis A** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
  - **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)
  - **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
  - **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

Hepatitis B vaccination

Routine vaccination

- **Age 19 through 59 years:** complete a 2- or 3-, or 4-dose series
  - 2-dose series only applies when 2 doses of Heplisav-B* are used at least 4 weeks apart
  - 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
  - 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])
  - 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months
  - 4-dose series Engerix-B at 0, 1, 2, and 6 months for persons on adult hemodialysis (note: each dosage is double that of normal adult dose, i.e., 2 mL instead of 1 mL)

***Note:** Heplisav-B not recommended in pregnancy due to lack of safety data in pregnant women

Special situations

- **Age 60 years or older* and at risk for hepatitis B virus infection:** 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above
  - **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
  - **HIV infection**
  - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)
  - **Current or recent injection drug use**
  - **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; patients with diabetes)
  - **Incarcerated persons**
  - **Travel in countries with high or intermediate endemic hepatitis B**

***Note:** Anyone age 60 years or older who does not meet risk-based recommendations may still receive Hepatitis B vaccination.

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all persons through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed

Notes Recommended Adult Immunization Schedule, United States, 2022

- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.**

Shared clinical decision-making

- **Some adults age 27–45 years: Based on shared clinical decision-making,** 2- or 3-dose series as above

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**
  - **Immunocompromising conditions, including HIV infection**: 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
  - **Pregnancy**: Pregnancy testing is not needed before vaccination; HPV vaccination is not recommended until after pregnancy; no intervention needed if inadvertently vaccinated while pregnant

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- For the 2021–2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm
- For the 2022–23 season, see the 2022–23 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only:** any influenza vaccine appropriate for age and health status annually
- **Egg allergy–any symptom other than hives** (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions
- **History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine:** Generally, should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
  - **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm^3 for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **Health care personnel:**
  - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose series MenACWY-D (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi) and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, or microbiologists routinely exposed to *Neisseria meningitidis*:**
- 2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains

Notes Recommended Adult Immunization Schedule, United States, 2022

- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks
- For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
- For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

Special situations

- **Age 19–64 years** with certain underlying medical conditions or other risk factors** who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
- For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

*__Note:__ Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

**__Note:__ Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Previously did not receive Tdap at or after age 11 years:** 1 dose Tdap, then Td or Tdap every 10 years

Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis:** 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose), Td or Tdap every 10 years thereafter
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
  - Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm^3 with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older:** 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including HIV):** RZV recommended for use in persons age 19 years or older who are or will be immunodeficient or immunosuppressed because of disease or therapy. For detailed information, see www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm.

Appendix Recommended Adult Immunization Schedule, United States, 2022

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2021-22 Seasonal Influenza with Vaccines available at www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm*

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Adults age 50 years or older • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Appendix Recommended Adult Immunization Schedule, United States, 2022

Vaccine	Contraindications[1]	Precautions[2]
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A- Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero); MenB-FHbp (Trumenba)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid–containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV20)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid—containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever • Current herpes zoster infection

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

County of Riverside - RUHS Public Health

DISEASE REPORTING REQUIREMENTS

DISEASES TO BE REPORTED IMMEDIATELY BY TELEPHONE

ANTHRAX, human or animal+
BOTULISM (Infant, Foodborne, Wound, Other)+
BRUCELLOSIS, human+
CHOLERA*
CIGUATERA FISH POISONING (Community acquired only)
CORONAVIRUS DISEASE 2019 (COVID-19)
DIPHTHERIA+
DOMOIC ACID POISONING (Amnesic shellfish poisoning)
FLAVIVIRIUS INFECTION of undetermined species
HEMOLYTIC UREMIC SYNDROME
INFLUENZA DUE TO NOVEL STRAINS, (human)+
MEASLES (Rubeola)+
MENINGOCOCCAL INFECTIONS
MIDDLE EAST RESPIRATORY SYNDROME (MERS)
NOVEL CORONAVIRUS INFECTION
NOVEL VIRUS INFECTION with pandemic potential**
PARALYTIC SHELLFISH POISONING
PLAGUE, Human or Animal+
RABIES, Human or Animal+
SCOMBROID FISH POISONING
SHIGA TOXIN (detected in feces)+
SMALLPOX (Variola)+
TULAREMIA, human+
VIRAL HEMORRHAGIC FEVERS, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg Viruses)+
OCCURENCE OF ANY UNUSUAL DISEASE
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.)

DISEASES OR SUSPECTED DISEASES TO BE REPORTED WITHIN ONE DAY OF IDENTIFICATION

BABESIOSIS+
CAMPYLOBACTERIOSIS*+
CHICKEN POX (Varicella)(Outbreaks, hospitalizations and deaths)
CHIKUNGUNYA Virus Infection
CRYPTOSPORIDIOSIS+
DENGUE VIRUS INFECTION+
ENCEPHALITIS+, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
ESCHERICHIA COLI: shiga toxin producing (STEC) including *E. coli O*157 *+
FOODBORNE DISEASE
HAEMOPHILUS INFLUENZAE, Invasive Disease all serotypes (report an incident if < 5 years of age)+
HANTAVIRUS INFECTION+
HEPATITIS A, acute infection *[1]+
HUMAN IMMUNODEFICIENCY VIRUS (HIV), Acute Infection++
LISTERIOSIS+
MALARIA+
MENINGITIS, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
PARATYPHOID FEVER
PERTUSSIS (Whooping cough)+
POLIOVIRUS INFECTION+
PSITTACOSIS+
Q FEVER+
RELAPSING FEVER+
SALMONELLOSIS (Other than Typhoid Fever)*+
SHIGELLOSIS*+
SYPHILIS (All stages, including congenital)+
TRICHINOSIS+
TUBERCULOSIS*+[3]
TYPHOID FEVER, Cases and Carriers*+
VIBRIO INFECTIONS *+
WEST NILE VIRUS (WNV) infection, acute +
YERSINIOSIS+
YELLOW FEVER+
ZIKA VIRUS INFECTION+

DISEASES TO BE REPORTED WITHIN SEVEN CALENDAR DAYS

ANAPLASMOSIS+
BRUCELLOSIS, animal (except infections due to Brucella canis)+
CHANCROID+
COCCIDIOIDOMYCOSIS+
CREUTZFELDT-JAKOB DISEASE (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
CYCLOSPORIASIS+
CYSTICERCOSIS OR TAENIASIS
EHRLICHIOSIS+
GIARDIASIS+
GONOCOCCAL INFECTION
HEPATITIS B (Specify acute, chronic or perinatal) [1]*++
HEPATITIS C (Specify acute, chronic or perinatal)[2]+
HEPATITIS D (Delta) (Specify acute case or chronic)[1]+
HEPATITIS E, acute infection [1]+
HUMAN IMMUNODEFICIENCY VIRUS (HIV) infection, any stage
HUMAN IMMUNODEFICIENCY VIRUS (HIV), (Non-acute infection)
HUMAN IMMUNODEFICIENCY VIRUS (HIV) infection, progression to stage 3 (AIDS)
INFLUENZA (ICU and Associated deaths in laboratory-confirmed cases for ages 0-64 years)***
LEGIONELLOSIS+
LEPROSY (Hansen's Disease) Occurrence of any unusual disease
LEPTOSPIROSIS+
LYME DISEASE
MUMPS+
RESPIRATORY SYNCYTIAL VIRUS (RSV)-associated deaths in laboratory-confirmed cases < 5 years of age)
RICKETTSIAL DISEASES (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illness)+
ROCKY MOUNTAIN SPOTTED FEVER+
RUBELLA (German Measles)+
RUBELLA SYNDROME, Congenital
TETANUS
TULAREMIA, animal+

REPORTABLE NON-COMMUNICABLE DISEASES AND CONDITIONS

ALZHEIMER'S DISEASE AND RELATED CONDITIONS
ANIMAL BITE (SEE REVERSE)
CANCER (SEE PAGE 3)***
DISORDERS CHARACTERIZED BY LAPSES OF CONSCIOUSNESS
MICROCEPHALY (ANY CAUSE)***
PESTICIDE EXPOSURE (SEE REVERSE)

* Essential to include occupation
\+ Must also be reported by laboratories
[1] Viral Hepatitis: All Hepatitis reports must include lab results and the date of onset. Hepatitis A: include occupation. Hepatitis B: if pregnant, include EDC.
[2] Please differentiate Acute Hepatitis C cases on the CMR. Chronic Hepatitis C indicated by positive anti-HCV test in an asymptomatic person should still be reported and should include confirmatory test results and supporting labs.
[3] Special Requirements for TB:
1. Health care provider is responsible for reporting TB results from out-of-state labs.
2. Laboratories that isolate *Mycobacterium tuberculosis* from a patient's specimen must follow requirements for submission of a culture to the Public Health Lab and drug susceptibility testing (Copy of requirements available upon request).
3. Active or suspected cases require approval of the Health Officer (or designee) prior to discharge/transfer from a health care facility.
4. Newly infected persons listed below must be reported:
   a) TB Converters: Those with an increase in the size of the tuberculin reaction by at least 10 mm of induration within 2 years from a documented negative to positive TST, or those who have a documented negative IGRA followed by a positive IGRA within a 2-year period.
   b) Children 3 years of age or younger with a positive TB skin test (5mm or greater).

** 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

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643, and §2800-2812
Reportable Diseases and Conditions

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 filled out. **All** 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 . Please use the COVID-19 CMR for reporting Novel Coronavirus and MIS-COVID

Disease Control
P.O. Box 7600
Riverside, CA 92513-7600
Phone: (951) 358-5107
Confidential Fax: (951) 358-5446

HIV/STD Program
P.O. Box 7600
Riverside, CA 92513-7600
Phone: (951) 358-7820
Fax: (951) 358-6007

NIGHT AND WEEKEND EMERGENCIES
(951) 782-2974

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 the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx)

HOW TO REPORT ALL HIV CASES:

Call (951) 358-7820 to report
Mail in a double envelope stamped **"Confidential"** to:
HIV/STD Surveillance Unit
P. O. Box 7600
Riverside, CA 92513-7600

OR

Fax to (951)358-6007, if faxing please call (951)358-7820 to confirm receipt

ALWAYS use CDPH form 8641-A rev. 05/13 (Adult) to report cases 13 years of age and older. For pediatric cases call (951) 358-7820 to report.
**It is recommended that mailed reports are sent via Certified or Registered mail for tracking purposes.*

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 may be controlled by this regulation and local ordinances (California Administration Code, Title 17, Sections 2606 et seq.: Health and Safety Code Sections 121575-120435). Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing your report. Call (951) 358-7327 or (951) 358-7387.
Report form is available at www.rivco-diseasecontrol.org

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 Office 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/Pestrpt.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).

CANCER REPORTING: 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):

SEVERE INFLUENZA (ICU or fatal cases) 0-64 years of age ***

* The Confidential Morbidity Report (CMR) is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). The CMR form can be found here: Communicable Disease Reporting Forms. 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.ccrcal.org.

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www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

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).

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 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.
- **§ 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 a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆! = Report immediately by telephone (designated by a ♦ in regulations).

† = 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).

FAX ✆ ✉ = 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(j)(1)

FAX ✆ ✉	Amebiasis
	Anaplasmosis
✆ !	Anthrax, human or animal
FAX ✆ ✉	Babesiosis
✆ !	Botulism (Infant, Foodborne, Wound, Other)
	Brucellosis, animal (except infections due to *Brucella canis*)
✆ !	Brucellosis, human
FAX ✆ ✉	Campylobacteriosis
	Chancroid
FAX ✆ ✉	Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
FAX ✆ ✉	Chikungunya Virus Infection
	Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ !	Cholera
✆ !	Ciguatera Fish Poisoning
	Coccidioidomycosis
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉	Cryptosporidiosis
	Cyclosporiasis
	Cysticercosis or taeniasis
✆ !	Dengue Virus Infection
✆ !	Diphtheria
✆ !	Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
	Ehrlichiosis
FAX ✆ ✉	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	*Escherichia coli* : shiga toxin producing (STEC) including *E. coli* O157
✆ !	Flavivirus infection of undetermined species
† FAX ✆ ✉	Foodborne Disease
	Giardiasis
	Gonococcal Infections
FAX ✆ ✉	*Haemophilus influenzae,* invasive disease, all serotypes (report an incident of less than five years of age)
FAX ✆ ✉	Hantavirus Infections
✆ !	Hemolytic Uremic Syndrome
FAX ✆ ✉	Hepatitis A, acute infection
	Hepatitis B (specify acute case or chronic)
	Hepatitis C (specify acute case or chronic)
	Hepatitis D (Delta) (specify acute case or chronic)
	Hepatitis E, acute infection
	Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS)
✆	Human Immunodeficiency Virus (HIV), acute infection
	Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ !	Influenza, novel strains (human)
	Legionellosis
	Leprosy (Hansen Disease)
	Leptospirosis
FAX ✆ ✉	Listeriosis
	Lyme Disease
FAX ✆ ✉	Malaria
✆ !	Measles (Rubeola)
FAX ✆ ✉	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	Meningococcal Infections
	Mumps
✆ !	Novel Virus Infection with Pandemic Potential
✆ !	Paralytic Shellfish Poisoning
FAX ✆ ✉	Pertussis (Whooping Cough)
✆ !	Plague, human or animal
FAX ✆ ✉	Poliovirus Infection
FAX ✆ ✉	Psittacosis
FAX ✆ ✉	Q Fever
✆ !	Rabies, human or animal
FAX ✆ ✉	Relapsing Fever
	Respiratory Syncytial Virus (RSV) ∞ (Report persons of all ages)
	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
	Rocky Mountain Spotted Fever
	Rubella (German Measles)
	Rubella Syndrome, Congenital
FAX ✆ ✉	Salmonellosis (Other than Typhoid Fever)
✆ !	Scombroid Fish Poisoning
✆ !	Shiga toxin (detected in feces)
FAX ✆ ✉	Shigellosis
✆ !	Smallpox (Variola)
FAX ✆ ✉	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉	Syphilis
	Tetanus
FAX ✆ ✉	Trichinosis
FAX ✆ ✉	Tuberculosis
	Tularemia, animal
✆ !	Tularemia, human
FAX ✆ ✉	Typhoid Fever, Cases and Carriers
FAX ✆ ✉	*Vibrio* Infections
✆ !	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉	West Nile Virus (WNV) Infection
✆ !	Yellow Fever
FAX ✆ ✉	Yersiniosis
✆ !	Zika Virus Infection
✆ !	OCCURRENCE of ANY UNUSUAL DISEASE
✆ !	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specify if institutional and/or open community.

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

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):

∞ = 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.

* 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.ccrcal.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	Subsection (e)(2) 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)**	**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** ***Entamoebe 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 (Rubeola), acute infection** **Mumps (mumps virus), acute infection** ***Mycobacterium tuberculosis*** ***Neisseria meningitidis*** (sterile site isolate) **Plague (*Yersinia pestis*), human or animal** **Poliovirus** **Psittacosis (*Chlamydophila psittaci*)** **Q Fever (*Coxiella burnetii*)** **Rabies,** animal or human **Relapsing Fever (*Borrelia 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 (*Richettsia 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.

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMEN

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.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (After Delivery)

Height _____ ins.

Weight _____ lbs. Measurement date _____

Hemoglobin _____ gm/dl.
and/or
Hematocrit _____ % Blood test date _____

PREGNANCY OUTCOME

Delivery date _____

	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Birth weight	Birth length
1.	☐	☐	☐	☐	☐			
2.	☐	☐	☐	☐	☐			

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

- ☐ C-Section
- ☐ Diabetes
- ☐ Hypertension
- ☐ Tuberculosis

_____ +PPD _____ INH

- ☐ Other conditions occurring during this pregnancy for delivery (specify):
- ☐ Other current or historical medical conditions (specify):

LOCAL WIC AGENCY

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number:

IMPORTANT: Must be signed by health care provider Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

CDPH

This institution is an equal opportunity provider.

CDPH 247B Rev 04/17 I #930028

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

PRINT FORM RESET FORM

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR PREGNANT WOMEN

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.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (PRENATAL)

Height _____ ins. Measurement date _____

Weight _____ lbs. _____

Hemoglobin _____ gm/dl. Blood test date _____

and/or

Hematocrit _____ % _____

Est. date confinement _____

Date last preg. ended _____

Gravida _____ Para _____

Pregravid weight _____ lbs.

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

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

CDPH

This institution is an equal opportunity provider.

CDPH 247C Rev 04/17 | #930028

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

PRINT FORM RESET FORM

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

Pediatric Referral

WIC Agency:

WIC ID#:

SECTION I: ***Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.***

PATIENT NAME: (First) (Last)				DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz inches

HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.

Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date

LEAD TEST (recommended at 1–2 years of age): _____ mcg/dL

IMMUNIZATIONS are up-to-date:

☐ Yes ☐ No ☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):

☐ Fully breastfeeding ☐ Never breastfed ☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding (Date: _____)

SECTION II: ***Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.***

DIAGNOSIS:

☐ Prematurity ☐ GERD or reflux ☐ Food allergy: _____

☐ Failure to thrive ☐ Dysphagia ☐ Other: _____

FORMULA / MEDICAL FOOD: _____

DURATION: _____ months **AMOUNT:** _____ oz / day

This prescription is: ☐ New ☐ Refill

NOTE: At 1 year of age, 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 (see WIC Food Restrictions).

COMMENTS:

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.

Category	WIC Foods	Do Not Give	Restriction / Comment
Infants (6–12 mo)	Baby cereal		
	Baby fruit / vegetable		
Children (1–5 yr)	Cow's milk		
	Cheese		
	Eggs		
	Peanut butter		
	Whole grains *		
	Cereal		
	Beans		
	Vegetables / fruits		
	Juice		
	Yogurt		

*** whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal**

HEALTH COVERAGE: ***Refer patient to their 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:

Private insurance: _____

Medi-Cal managed care: _____

Other: _____

Regular Medi-Cal (fee-for-service): ☐ Yes ☐ No

Check action taken:

☐ Submitted justification to health plan

☐ Submitted justification to pharmacist

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 Care Professionals; then click WIC contacts for MDs.

COMMENTS:

HEALTH PROFESSIONAL NAME	HEALTH PROFESSIONAL SIGNATURE	MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
PHONE NUMBER	TODAY'S DATE	

The information above is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original form. **This institution is an equal opportunity provider and employer.**

PRINT FORM RESET FORM

Authorization of Release

Use & Disclosure of Protected Health Information

IEHP® A Public Entity
Inland Empire Health Plan

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).

Member Name _____ Member ID # or Social Security # _____ Date of Birth _____

RECORD REQUEST

REQUIRED

Please indicate the type of PHI records you are requesting:*

☐ Prescription ☐ Grievance & Appeals Case Management ☐ Referrals/Authorizations
☐ Claims/Billing ☐ 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) _____
☐ Care Management ☐ Care Coordination

* 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.

SPECIFIC AUTHORIZATIONS

REQUIRED

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
☐ HIV Test Results and Treatment Information
☐ I do not request the disclosure of such records
☐ Mental Health Treatment Information *(does NOT include psychotherapy notes)*
☐ Other _____

RECORD DELIVERY

REQUIRED

Delivery Options: (please check one)

☐ Pick-up at IEHP (Temporary hours for pickup are Fridays 8am to 11am)*

* 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 (No fee to member): No P.O. Box Available
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 _____.

Authorization of Release

Use & Disclosure of Protected Health Information

IEHP
A Public Entity
Inland Empire Health Plan

AUTHORIZATION

REQUIRED

I hereby authorize: _____

(Please list IEHP here if you are requesting records from IEHP. If not, please list the name or description of the person or entity to which you are requesting the disclosure of records from)

Address: _____

City, State, Zip Code: _____

Phone: _____

To release information to: _____

(Please list your name here if use and/or disclosure will be made to you. If not, please list specify the name of the person or entity to which the use and/or disclosure will be made to, such as a family member, attorney, facility, provider, IEHP, etc.)

Address: _____

City, State, Zip Code: _____

Phone: _____

This authorization is a two-way authorization and shall authorize both named parties above to exchange the protected health information stated below between each other: ☐ Yes ☐ No

SIGNATURES

REQUIRED

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

Name of Member (printed) _____ Signature of Member _____ Date _____

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.

Name of Member's Legal Representative (printed) _____ Signature of Member's Legal Representative _____ Date _____

The Authorization is effective immediately and will remain in effect until ____/____/_____.
(ending date)

This consent is subject to revocation at any time except to the extent that any other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it.

DISCLOSURES

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.

I understand that my substance use disorder records are protected under the Federal Regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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

FOR INTERNAL USE ONLY
Authorization contains Privileged and Confidential Information.

Rev. 11/2020

Autorización de Divulgación

Uso y Divulgación de la Información Médica Protegida

Inland Empire Health Plan

La Ley de Portabilidad y Responsabilidad del Seguro Médico *(Health Insurance Portability and Accountability Act, HIPAA)*, las normas federales y la legislación de California exigen que se llene esta Autorización con el fin de autorizar a Inland Empire Health Plan (IEHP) a usar y divulgar Información Médica Protegida *(Protected Health Information, PHI)*.

Nombre del Miembro _____ N.º de Identificación o N.º Seguro Social del Miembro _____ Fecha de Nacimiento _____

SOLICITUD DE REGISTROS

Indique el tipo de registros de PHI que está solicitando:* ***OBLIGATORIO***

☐ Receta Médica ☐ Administración de Casos de Quejas Formales y Apelaciones ☐ Referencias/Autorizaciones
☐ Reclamos/Facturación ☐ Inscripción/Elegibilidad

Ingrese el rango de fechas de los registros de PHI que necesita: ____/____/____ al ____/____/____

Indique el(los) fin(es) para divulgar o usar la PHI:

☐ Legal ☐ Uso Personal ☐ Seguros ☐ Otro (Especifique) _____
☐ Administración de Atención Médica ☐ Coordinación de Atención Médica

* IEHP no mantiene registros médicos y/o clínicos individuales. Estos registros están en poder de los profesionales/las entidades que prestaron el(los) servicio(s) médico(s), es decir, los Doctores de Cuidado Primario, Especialistas, Hospitales, etc.

AUTORIZACIONES ESPECÍFICAS

Autorizaciones Específicas: ***OBLIGATORIO***

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 tales registros, proporcione una autorización específica ***colocando sus iniciales en la(s) casilla(s) correspondiente(s)*** *a continuación:*

☐ Información sobre el Tratamiento de Abuso de Drogas/Alcohol
☐ Resultados de las Pruebas de VIH e Información sobre el Tratamiento
☐ No solicito la divulgación de tales registros
☐ Información sobre Tratamientos de Salud Mental *(NO incluye notas de psicoterapia)*
☐ Otro _____

ENTREGA DE REGISTROS

Opciones de Entrega: (marque una opción) ***OBLIGATORIO***

☐ Recoger Registros en IEHP (Horario temporal para recoger los registros: viernes, 8am a 11am)*

* Si elige pasar a recoger sus registros, el Departamento de Asuntos Legales de IEHP se comunicará con usted cuando sus registros estén disponibles. Sus registros estarán disponibles para que los recoja durante 14 días hábiles. Si sus registros no se recogen dentro de los 14 días hábiles, se destruirán.

☐ Entrega por FedEx (Sin cargo para el Miembro): No se Dispone de Apartado Postal
Dirección de Entrega _____

☐ Portal de Correo Electrónico Seguro*
Dirección de Correo Electrónico _____

* Para proteger su privacidad, IEHP divulga la PHI usando un portal de correo electrónico seguro. A solicitud, IEHP puede divulgar su PHI usando un portal de correo electrónico no codificado y no seguro. Sin embargo, IEHP no es responsable de vulneraciones de la seguridad que pudieran ocurrir si la PHI se envía usando un correo electrónico no codificado y no seguro. Si usted solicita a IEHP que divulgue su PHI usando un portal de correo electrónico no codificado y no seguro, y acepta los riesgos de seguridad que implica el uso de este método, coloque sus iniciales aquí _____.

Autorización de Divulgación

Uso y Divulgación de la Información Médica Protegida

Inland Empire Health Plan

AUTORIZACIÓN

Mediante el presente documento autorizo: _____
(Indique IEHP aquí si está solicitando registros de IEHP. Si no es así, indique el nombre o la descripción de la persona o entidad de la que está solicitando la divulgación de los registros)

_____
Dirección:

_____
Ciudad, Estado, Código Postal:

_____
Teléfono:

Para divulgar información a: _____ ***OBLIGATORIO***
(Indique su nombre aquí si el uso y/o la divulgación estarán dirigidos a usted. Si no es así, indique/especifique el nombre de la persona o entidad a la que se dirigirá el uso y/o la divulgación, tal como un familiar, abogado, establecimiento, proveedor, IEHP, etc.)

_____
Dirección:

_____
Ciudad, Estado, Código Postal:

_____
Teléfono:

Esta autorización es bilateral y autorizará a ambas partes mencionadas arriba a que intercambien entre ellas la información médica protegida que se indica a continuación: ☐ Sí ☐ No

FIRMAS

Leí esta Autorización y acepto el uso y la divulgación de la PHI según lo especificado. ***OBLIGATORIO***

_____ _____ _____
Nombre del Miembro (en letra de molde) Firma del Miembro Fecha

Si firma por el Miembro, describa su autoridad para actuar en nombre del Miembro *(p. ej., padre del menor o tutor legal):* _____

Nota: La documentación apropiada de la autoridad del representante legal debe estar registrada con IEHP.

_____ _____ _____
Nombre del Representante Legal del Miembro (en letra de molde) Firma del Representante Legal del Miembro Fecha

Las Autorizaciones entran en vigencia de inmediato y permanecerán vigentes hasta el _____/_____/_____.
(fecha de finalización)

Este consentimiento está sujeto a revocación en cualquier momento, excepto hasta el punto que cualquier otro titular legal de información de identificación del paciente que tenga permitido realizar la divulgación ya haya actuado en virtud de la autorización.

DIVULGACIONES

AVISO DE DERECHOS Y OTRA INFORMACIÓN

Entiendo que no estoy obligado a firmar esta Autorización. El hecho de que me niegue a firmarla no afectará mi capacidad de obtener tratamiento, recibir pagos o ser elegible para recibir los beneficios. Estoy informado de que tengo derecho a revocar esta Autorización en cualquier momento, siempre que mis revocaciones se hagan por escrito. Entiendo que tengo derecho a recibir una copia. Entiendo también que si la información provista por esta Autorización se divulga (proporciona) a otra persona o agencia, es posible que ya no esté protegida por la ley de confidencialidad federal (HIPAA). No obstante, la legislación de California no permite que la persona que reciba la información médica en virtud de esta Autorización la divulgue, a menos que yo brinde una nueva Autorización para dicha divulgación, o a menos que la ley exija o permita específicamente dicha divulgación.

Entiendo que mis registros sobre trastornos por abuso de sustancias están protegidos conforme a las Normas Federales que rigen los Registros de Confidencialidad del Paciente sobre Trastornos por Abuso de Sustancias, 42 C.F.R. Parte 2, y la Ley de Portabilidad y Responsabilidad del Seguro Médico ("HIPAA") de 1996, 45 C.F.R. pts 160 & 164, y no se pueden divulgar sin mi consentimiento por escrito, a menos que las normas estipulen lo contrario.

IEHP actuará en virtud de esta solicitud dentro de los 30 días de la fecha en que se haya recibido la Autorización o dentro de los 60 días si la información solicitada no se mantiene o no es accesible para IEHP en el sitio.

Complete todas las secciones obligatorias, firme y envíe 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

PARA USO INTERNO ÚNICAMENTE
La Autorización contiene Información Privilegiada y Confidencial. *Rev. 11/2020*