State of Illinois
Department of Human Services

PRIMARY CARE PHYSICIAN (PCP) NOTIFICATION FORM
REPORT of HIGH RISK INFANT FOLLOW-UP PROGRAM

Agency Reporting: ______________________________

Public Health Nurse Case Manager: ______________________________

Contact Number: ______________________________

Last Name of Infant: ______________________________

First Name of Infant: ______________________________

Infant's Birth Date: ______________________________

Chronological Age: ________Weeks ________Months Gestational Age: ________Weeks ________Months

Street Address: ______________________________

City: ______________________________ State: ______________

Mother's Name:(Last, First) ______________________________

Date of most recent Public Health Nurse visit: ______________________________

Assessment Findings during Last Visit:

- Physical Exam (*): ______________________________

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  (* *Attach copies of the child's immunization history and EPSDT visits*.)

- Development Assessment: ______________________________
- Anticipatory Guidance Provided: ______________________________
- Referrals Made (as needed): ______________________________

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Comments: ______________________________

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