
City of Berkeley
Department of Health and Human Services
Public Health Division

# Prevalence of Obesity, Underweight, and Anemia in the Child Health and Disability Prevention Program (CHDP), Berkeley, 2007-2008

**Prepared by**

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# PREVALENCE OF OBESITY, UNDERWEIGHT, AND ANEMIA IN THE CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP), BERKELEY, 2007-2008

## SUMMARY

Obesity is a national critical child health problem. Childhood obesity has been linked with adult obesity. Adult obesity is associated with an increased risk for a wide range of chronic illnesses, such as heart disease, diabetes and some cancers.

Since 2005, the Public Health Division has analyzed data collected from local physicians who examined low-income Berkeley children. In fiscal year 2007/8, the percentage of obese children 0 to 19 years older was 14.4%. This represents a large reduction since 2005, when the percentage was 24.2%. In FY 2007/8, approximately 9.9% of 0-4 year olds and 23.9% of 5 to 19 year olds were obese. The overall rate of obesity in Berkeley is slightly lower than that of Alameda County or California. Neither Alameda County nor California showed a significant decrease in childhood obesity since 2005. Unlike obesity, the percentage of underweight children (7.0%) or those with anemia (4.7%) did not show a changing trend since 2005.

Although the prevalence of obesity in FY 2007/8 has improved compared to the Berkeley baseline measurement in 2005, it is now comparable to the Alameda County average, and is still unacceptably high. We recommend that the City of Berkeley Public Health Division and our community partners take the following action:

- Encourage and support greater participation among students in breakfast programs at their schools and increase enrollment for the healthy free- and reduced- lunch program.
- Facilitate policy development related to the overall food environment, for example menu labeling requirements for Berkeley restaurants.
- Increase support and follow-up on registering eligible individuals for Electronic Benefit Transfer, EBT (to access farmers' markets, retailers that accept food stamps) and/or Women, Infants, Children (WIC) programs and benefits.
- Provide mini-grants for community residents or community-based organizations that provide innovative solutions and programs that encourage healthy eating and physical activity for youth.
- Explore joint use agreements for school sites and recreation sites for evening and weekend for use by physical activity programs for children and families.
- Offer nutrition education and cooking classes for parents to encourage healthy eating.
- Build partnerships with City of Berkeley Parks and Recreation, Planning Division, and Law Enforcement to create safe, accessible green spaces for children to play and exercise.

## INTRODUCTION

The Child Health and Disability Prevention Program (CHDP) provides health care and periodic preventive health assessments to California children in low-income families. Eligible children include all Medi-Cal recipients through age 20 and other low-income eligible children up to 19 years of age. As part of routine assessments, physicians monitor childhood physical development and indicators of anemia. To receive reimbursement for services physicians submit encounter forms (PM 160s) that record the child's age, sex, weight, height or length, hemoglobin, and hematocrit. These administrative data are part of a state and national surveillance system for monitoring childhood obesity and anemia.[1]

Local physicians provide copies of the PM 160 form to local health departments and to the California Department of Health Care Services (formerly Department of Health Services), which key-enters data and provides extracts to the Centers for Disease Control (CDC), as part of the national Pediatric Nutrition Surveillance System (PedNSS). Physicians indicate on the PM 160 form the county health jurisdiction in which the patient resides. A previous assessment of PM 160s submitted to the Public Health Division in 2005 indicated that over 90% of Berkeley providers use the code for Alameda County (01) rather than Berkeley's code (59).[2] Consequently, statistical analyses of the data key-entered by the State of California and CDC misclassify the overwhelming majority of Berkeley encounters as Alameda County encounters, thus leaving Berkeley with few observations in official statistics (e.g. 104 children in 2005).

This study, which used all PM160 paper forms submitted to the Public Health Division as a data source, was undertaken to accurately estimate the prevalence of obesity and anemia in Berkeley's CHDP population using methods comparable to those used since 2005[2], and to examine changes in the prevalence of obesity and anemia since 2005.

## MATERIALS AND METHODS

### Data Source

The data source was PM 160 encounter forms (See Appendix) for services rendered between July 1, 2007 and June 30, 2008 (measurement year, FY2007/8) and received by the Berkeley Public Health Division by December 31. The PM 160 reporting was thought to be complete due to the allowance of a greater than 4 month claims lag.

### Sample

Insufficient resources did not allow over 1700 PM 160 encounter forms to be abstracted and logged for the entire measurement year. After discussion with the CHPD staff, it was determined to take a three months sample, which reflected typical seasonal volume variation (September 2007, January 2008, May 2008). These months fell within the measurement period (7/1/2007-6/30/2008) and were based on a fiscal year, similar to the two previous studies. The use of the fiscal year was chosen in order to synchronize Berkeley's performance measurements with the requirements of the State of California.[3]

The minimum sample size of 190 was estimated based on an expected frequency of obesity of 16.7% (Alameda County average), and a margin of error of ± 5% with 95% confidence in a population of 1700 children.

**Data Collection**

Patient name, age, sex, ethnicity (American Indian, Asian, Black, Filipino, Hispanic, White, Other, Pacific Islander), county of residence code, weight and height/length, hemoglobin levels, and hematocrit were abstracted from each PM 160 form into an Excel spreadsheet. For patients with multiple visits or for duplicate entries, only most recent unique and complete entry was used. The Excel spreadsheet was imported into an SPSS program (provided by the Centers for Disease Control), which calculated the percentile score for weight of each child based on BMI-for-age in children 25 months to 19 years, and weight-for-length in children 24 months or younger.[1,4] Height/length measurements were assumed to be recumbent at ages 24 months and younger.

Definition of Obesity and Anemia

Children at the 95th% or greater weight distribution were classified as obese. (CDC's PedNSS describes this same cut-off as "overweight" at the 95$^{th}$%). Age-, sex-, cut-offs for low/normal hemoglobin were programmed using CDC guidelines.[5]

Data Quality

Missing data and outliers were assessed using frequency distributions. Due to missing and inaccurate information, BMI could not be calculated for 42 children. Hemoglobin and hematocrit were not recorded for most children (85%). Rather than exclude children with missing hemoglobins or hematocrits from the analysis of anemia, it was assumed that missing data were below thresholds for anemia. While this approach is consistent with previous analyses, the results are not comparable to PedNSS, which excludes any missing data from analysis. The resulting anemia prevalence is likely to be an underestimate, however, it provides information to detect changes in temporal trends.

Physicians classified the race of the majority of children as "Other". It is not known whether this reflects multiracial categories or underclassification of specific race/ethnicities. Because concerns with validity of this information, analyses of outcomes stratified by race/ethnicity were not performed.

Statistical Analysis

Frequency distributions of prevalence of anemia and obesity were calculated in age strata of 0-4 years of age and 5 to 19 years of age. These strata are used in published data at the state and county level to facilitate comparisons. 95% confidence intervals were calculated using the exact binomial distribution.

**RESULTS**

There were 412 unique children in the sample, 66.7% of whom were under 5 years old (Table 1). Males comprised 48.8%. Few children (<2%) had providers who used the correct jurisdiction code to identify the child as a Berkeley resident.

The prevalence of obesity was 9.9% in 0-4 year olds and 23.7% in 5-19 year olds (Table 2). At 0-4 years of age, males and females had a similar obesity prevalence, but at 5-19 years, males tended to have higher obesity rates than females (p=0.11). In each age strata, Berkeley's CHDP children had a similar prevalence of obesity as Alameda County. However, the

prevalence of obesity in Berkeley's CHDP 0-4 year olds was significantly lower than that of their California counterparts (p =0.01). The prevalence of underweight was 8.7%. In 0-4 year olds, Berkeley had a higher prevalence of underweight than that of Alameda County (p>.0.05) and California (p=.02) [Table 3].

The prevalence of anemia was 4% (Table 4).

### Time Trends 2005 to 2008

There was a statistically significant decline in the prevalence of obesity in Berkeley 0-4 year olds from 2005 to FY2007/8 (Table 5). The prevalence of underweight had a nonsignificant increase in both age groups from 2005 to FY2007/8. Anemia prevalence did not significantly differ by time period.

## DISCUSSION

From 2005 to 2008, there has been a significant decrease in the prevalence of obesity among Berkeley CHPD participants. This decline is apparent in both younger and older children, but the 0-4 years age group showed the largest reduction change over time. Berkeley CHDP children now have a prevalence of obesity on par with their counterparts in Alameda County and the State of California. The decreasing trend observed in Berkeley children was not observed in CHDP participants in Alameda County or California, whose prevalence was essentially unchanged between 2005 and 2007. In contrast to obesity, no significant changes were observed in the prevalence of underweight or anemia in Berkeley CHPD children.

We do not know with certainty the reason for the decreasing trend in obesity prevalence in Berkeley's CHDP children. Changes in Berkeley's population, activities of the Public Health Division's CHDP program and its partners, and other factors may contribute to the explanation.

Between 1990 and 2000, the percentage of low- and middle-income families has decreased in Berkeley, and African American families have borne a disproportionately large share of this decrease.[6] Likewise, there has been a small, steady decrease in the number of children in our annual 3-month samples. Although the eligibility requirements for CHDP have not changed, it is possible, albeit speculative, that the CHDP-eligible population that remains resident in Berkeley may have a lower prevalence of risk factors or higher prevalence of assets (e.g., education) that impact childhood obesity.

There is a small group of stable Berkeley pediatric and family practices that provide the bulk of care to CHDP children. Changes in access to care are not likely to explain changing obesity rates. However, in the last decade providers have begun to monitor physical development using age- and sex-specific growth charts incorporating body mass index (BMI) rather than height and weight, which tended to underdiagnose overweight and obesity in children.[4] Over this transition period, the Public Health Division CHDP program has routinely provided educational support for providers, often in collaboration with Medi-Cal managed care plans. An initial prevalence in 2005 that was higher than county-average may reflect an improved diagnosis in Berkeley providers. The decline may reflect increased counseling or referrals that may have indeed reduced obesity rates. It seems less likely that diagnostic sensitivity has changed because it is presumed that Berkeley providers continue to use BMI-specific growth charts. We do not have information on educational outreach to providers in non-Berkeley Alameda County that may shed light on changes in their diagnostic practices or referral patterns.

The CHDP program reviews PM160s and makes referrals to a public health nurse for uninsured children on a variety of issues, including anemia and overweight. The referral may culminate in a home visit or telephone consultation to provide or arrange nutritional counseling. However, in the FY2007/8 sample, of 17 patients who were referred, only 1 was related to obesity. Although public health nursing referrals for obesity may not have impacted obesity prevalence before 2008, they may play an important role in maintaining or accelerating post-2008 improvements.

**Data Quality**

Berkeley physicians have continued to use the Alameda County code (01) rather than the unique Berkeley code (59) to indicate the local health jurisdiction. The use of the proper code would obviate the need for this special survey. Pre-printing downloadable forms from the State website with the Berkeley code, or key entry of (Berkeley) city of residence by the State's commercial processor of PM160s has been suggested, but ruled out as technically or economically infeasible by State agencies.

The prevalence of race/ethnicity could not be taken into account due to the large amount of missing data. Since the measurements of hemoglobin or hematocrit were missing for the majority of the children, these measurements could not be analyzed. Providers must be continually reminded of the importance of collecting complete data, so the data can be compared to County and State benchmarks.

Despite the limitations of missing data, the administrative data of the CHDP program is a valuable resource in monitoring the prevalence of childhood obesity, which is a growing public health concern.[7] This data has also provided the opportunity to observe whether City of Berkeley obesity programs are having an impact in the community.

## CONCLUSIONS AND RECOMMENDATIONS

Obesity is a critical child health problem in Berkeley. Childhood obesity is associated with adult obesity, which in turn is associated with an increased risk for a wide range of chronic illnesses, including heart disease and some cancers. Public health interventions to prevent obesity are a high priority. Current Public Health Division programs to address this issue include:

- **Eat Well Berkeley** is a new community health program, sponsored by the Kaiser Permanente Healthy Eating Active Living Program. This program is designed to work with restaurants to provide healthy options for their customers, and to support and promote restaurants that provide healthy food choices. For restaurants that offer a kid's menu, one of the criteria for program participation is offering fruit or vegetables but neither French fries nor soda.

- **Corner Store Market Program** is an extension of our Eat Well Berkeley program that works with corner stores near our 3 middle schools and our continuation high school to offer healthier snack and beverage choices for students.

- **Be Fit Berkeley** is a community-wide campaign encouraging Berkeley citizens to eat healthy foods and exercise regularly. Anyone who lives or works in Berkeley can participate in the campaign by registering with the Public Health Division and tracking pounds lost or minutes exercised, and be eligible for raffle prizes.

- **Nutrition Education and Food Access Projects** – Through presentations, taste-testings, and various community outreach events, nutrition education aims to increase fruit and vegetable consumption and physical activity among low-income children and families. We work in collaboration with Head Start, Project BUILD, the Berkeley Unified School District, and various community organizations like Farm Fresh Choice, Berkeley Youth Alternatives, and Youth Spirit Artworks to improve access to affordable, healthy food and increase community awareness and participation in the local food system.

We recommend that the City of Berkeley and our community partners:

- Encourage and support greater participation among students in breakfast programs at their schools and increase enrollment for the healthy free- and reduced- lunch program.
- Facilitate policy development related to the overall food environment, for example menu labeling requirements for Berkeley restaurants.
- Increase support and follow-up on registering eligible individuals for Electronic Benefit Transfer, EBT (to access farmers' markets, retailers that accept food stamps) and/or Women, Infants, Children (WIC) programs and benefits.
- Provide mini-grants for community residents or community-based organizations that provide innovative solutions and programs that encourage healthy eating and physical activity for youth.
- Explore joint use agreements for school sites and recreation sites for evening and weekend for use by physical activity programs for children and families.
- Offer nutrition education and cooking classes for parents to encourage healthy eating.
- Build partnerships with City of Berkeley Parks and Recreation, Planning Division, and Law Enforcement to create safe, accessible green spaces for children to play and exercise.
- Disseminate this report to City Departments and community partners, including the BUSD and community-based organizations.

## ACKNOWLEDGMENTS

Public Health Division staff members Diane Covall, CHDP Coordinator; Kate Clayton and Tanya Moore, Health Promotion Section; Zandra Lee, Community Health Assessment and Action Section; and Janet Berreman, Health Officer, assisted with the review and editing of this report.

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2. Maizlish N, Lee W. Prevalence of Obesity, Underweight, and Anemia in Children in the Child Health and Disability Prevention Program (CHDP), Berkeley, 2005. Berkeley: Public Health Division, City of Berkeley; 4/25/07.

3. Children's Medical Services. CHDP Performance Measure - Childhood Overweight. Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-8. Sacramento: California Department of Health Care Services; 5/1/2007.

4. Centers for Disease Control and Prevention. The 2000 CDC Growth Charts and the New Body Mass Index-For-Age Charts (www.cdc.gov/growthcharts/). Atlanta, GA: Centers for Disease Control and Prevention; 2006.

5. Centers for Disease Control and Prevention. Recommendations to Prevent and Control Iron Deficiency in the United States. MMWR 1998;47(No. RR-3).

6. Breckwich-Vazquez V, Maizlish N, Ducos J, Rudolph L. City of Berkeley, Health Status Report, 2007. Berkeley: Public Health Division, Department of Health & Human Services, City of Berkeley; 2007.

7. Ogden CL, Flegal KM, Carroll MD, Johnson CL. Prevalence and trends in overweight among US children and adolescents, 1999-2000. JAMA 2002;288:1728-1732.

**Table 1.** Description of CHDP Population, 7/1/07-6/30/08*

| Item | N | Percent |
|---|---|---|
| Total | 412 | 100 |
| | | |
| Age (Years) | | |
| 0 – 4 | 275 | 68 |
| 5 – 19 | 131 | 32 |
| Missing | 6 | |
| | | |
| Sex | | |
| Male | 201 | 49 |
| Female | 211 | 51 |
| Missing | 0 | |
| | | |
| Ethnicity | | |
| Asian | 31 | 8 |
| African Am. | 51 | 14 |
| Filipino | 1 | <1 |
| Latino | 73 | 20 |
| White | 18 | 5 |
| Other | 197 | 53 |
| Missing | 41 | |
| | | |
| County Code | | |
| Alameda County (01) | 378 | 94 |
| Berkeley (59) | 16 | 4 |
| Others (7, 38,41) | 8 | 2 |
| Missing | 10 | |

* Sample months Sept. 2007, Jan. 2008, May 2008
Note: Missing data excluded from percentages

**Table 2.** Prevalence of Overweight (≥95$^{th}$%)$^{\dagger}$, CHDP, Berkeley, 7/1/07-6/30/08*

| | Ages 0-4 (N=252) | | Ages 5-19 (N=118) | | Total (N=370) | |
|---|---|---|---|---|---|---|
| Item | N | Percent | N | Percent | N | Percent |
| Berkeley Total | 25 | 9.9 | 28 | 23.7 | 53 | 14.3 |
| 95% CI | | 6.5 – 14.3 | | 16.4 – 32.4 | | 10.9 – 18.3 |
| | | | | | | |
| Sex | | | | | | |
| Male | 14 | 10.9 | 14 | 24.6 | 28 | 15.1 |
| Female | 11 | 8.9 | 14 | 23.0 | 25 | 13.6 |
| | | | | | | |
| Alameda Co., 2007 | 4,270 | 13.2 | 3,812 | 21.8 | | |
| California, 2007 | 157,619 | 15.5[a] | 109,305 | 23.1 | | |

† Based on BMI (> 2 years of age) and length for weight (0 < 2 years)
* Sample months Sept. 2007, Jan. 2008, May 2008;
[a] Significantly different than the State of California ($p < 0.05$);
CI, Confidence Interval

**Table 3.** Prevalence of Underweight† (< 5th Percentile), CHDP, Berkeley, 7/1/07-6/30/08*

| | Ages 0-4 (N=252) | | Ages 5-19 (N=118) | | Total (N=370) | |
|---|---|---|---|---|---|---|
| Item | N | Percent | N | Percent | N | Percent |
| Berkeley Total | 22 | 8.7 | 4 | 3.4 | 26 | 7.0 |
| 95% CI | | 5.6 – 12.9 | | 0.9 – 8.5 | | 4.6 – 10.1 |
| Sex | | | | | | |
| Male | 15 | 11.6 | 3 | 5.3 | 18 | 9.7 |
| Female | 7 | 5.7 | 1 | 1.6 | 8 | 4.3 |
| Alameda Co., 2007 | 2,135 | 6.6 | 472 | 2.7 | | |
| California, 2007 | 54,912 | 5.4[a] | 11,356 | 2.4 | | |

* Sample months Sept. 2007, Jan. 2008, May 2008
† Based on BMI (> 2 years of age) and length for weight (0 < 2 years)
[a] Significantly different than the State of California ($p < 0.05$);
CI, Confidence Interval

**Table 4.** Prevalence of Anemia, CHDP, Berkeley, 7/1/07-6/30/08*

| | Ages 0-4 (N=275) | | Ages 5-19 (N=131) | | Total (N=406) | |
|---|---|---|---|---|---|---|
| Item | N | Percent | N | Percent | N | Percent |
| Total | 11 | 4.0 | 8 | 6.1 | 19 | 4.7 |
| 95% CI | | 2.0 – 12.0 | | 2.7 – 11.7 | | 2.8 – 7.2 |
| Male | 5 | 3.6 | 3 | 4.9 | 8 | 4.0 |
| Female | 6 | 4.4 | 5 | 7.1 | 11 | 5.3 |

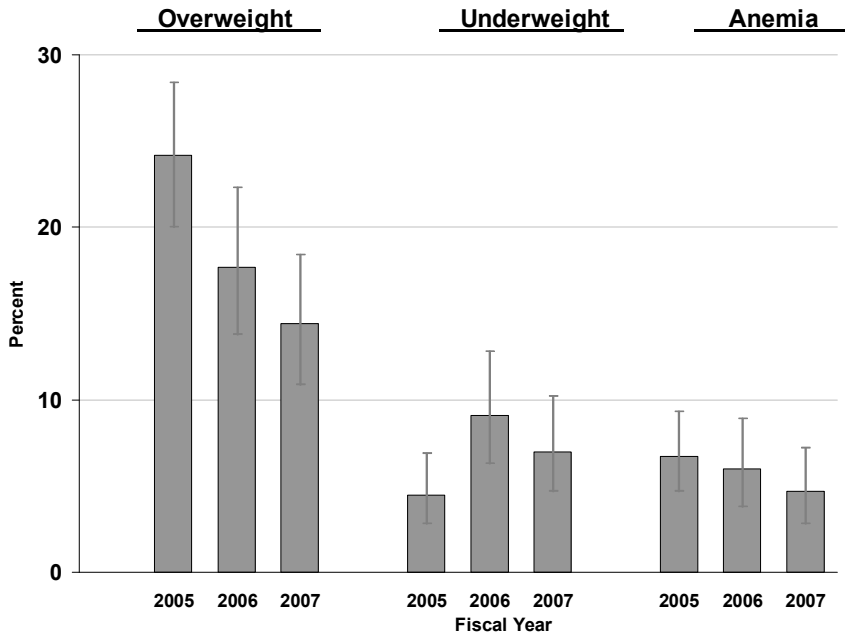
* Sample months Sept. 2007, Jan. 2008, May 2008

**Table 5**. Prevalence of Overweight (≥95th%), Underweight, and Anemia, CHDP, Berkeley, 2005, FY2006/7, FY2007/8*

| | 2005 | | | 2006-2007 | | | 2007-2008 | | |
|---|---|---|---|---|---|---|---|---|---|
| Item | N | % | $CI_{95\%}$ | N | % | $CI_{95\%}$ | N | % | $CI_{95\%}$ |
| Overweight | | | | | | | | | |
| Total | 107 | 24.2 | 20.0 – 28.4 | 58 | 17.7 | 13.8 – 22.3 | 53 | 14.3 | 10.9 – 18.3 |
| 0-4 | 59 | 21.0 | 15.6 – 25.8 | 34 | 14.0 | 9.9 – 19.0 | 25 | 9.9 | 6.5 – 14.3 |
| 5-19 | 48 | 29.8 | 22.9 – 37.5 | 24 | 28.6 | 19.2 – 39.5 | 28 | 23.7 | 16.4 – 32.4 |
| Underweight | | | | | | | | | |
| Total | 20 | 4.5 | 2.8 – 6.9 | 29 | 9.1 | 6.3 – 12.8 | 26 | 7.0 | 4.6 – 10.1 |
| 0-4 | 18 | 6.4 | 3.8 – 9.9 | 26 | 10.7 | 7.1 – 15.3 | 22 | 8.7 | 5.6 – 12.9 |
| 5-19 | 2 | 1.2 | 0.2 – 4.4 | 3 | 4.8 | 1.3 – 11.7 | 4 | 3.4 | 0.9 – 8.5 |
| Anemia | | | | | | | | | |
| Total | 33 | 6.7 | 4.7 – 9.3 | 23 | 6.0 | 3.8 – 8.9 | 19 | 4.7 | 2.8 – 7.2 |
| 0-4 | 18 | 5.7 | 3.3 – 8.8 | 13 | 4.6 | 2.5 – 7.8 | 11 | 4.0 | 2.0 – 12.0 |
| 5-19 | 15 | 8.7 | 4.9 –13.9 | 10 | 9.7 | 4.8 –17.1 | 8 | 6.1 | 2.7 – 11.7 |

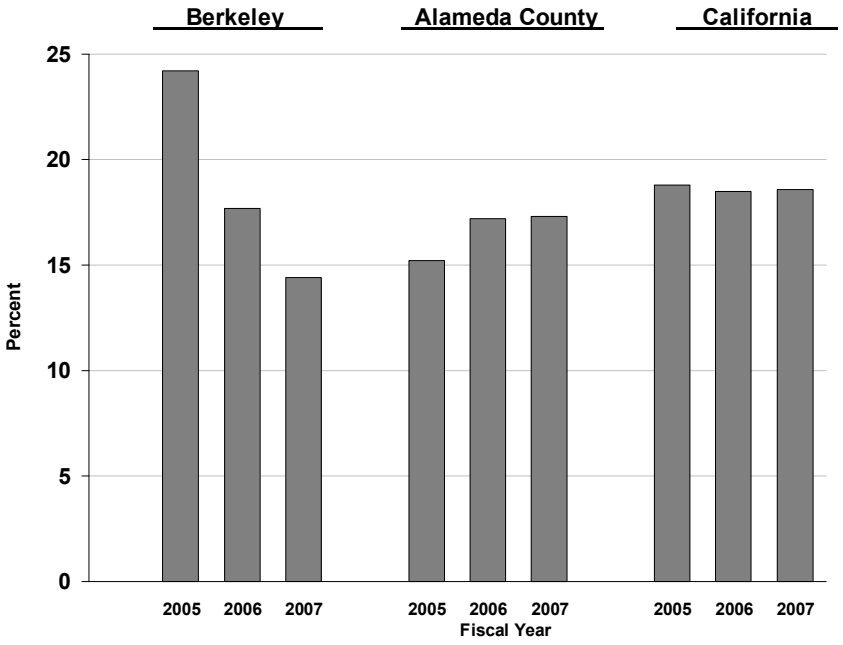
* Sample months 2005: Apr. 2005, August 2005, Dec. 2005
Sample months 2006-7, 2007-8: Sept., Jan., May
CI, Confidence Interval

**Figure 1. Prevalence of Total Overweight (≥95th%), Underweight, and Anemia, CHDP, Berkeley, 2005, FY2006/7, FY2007/8**



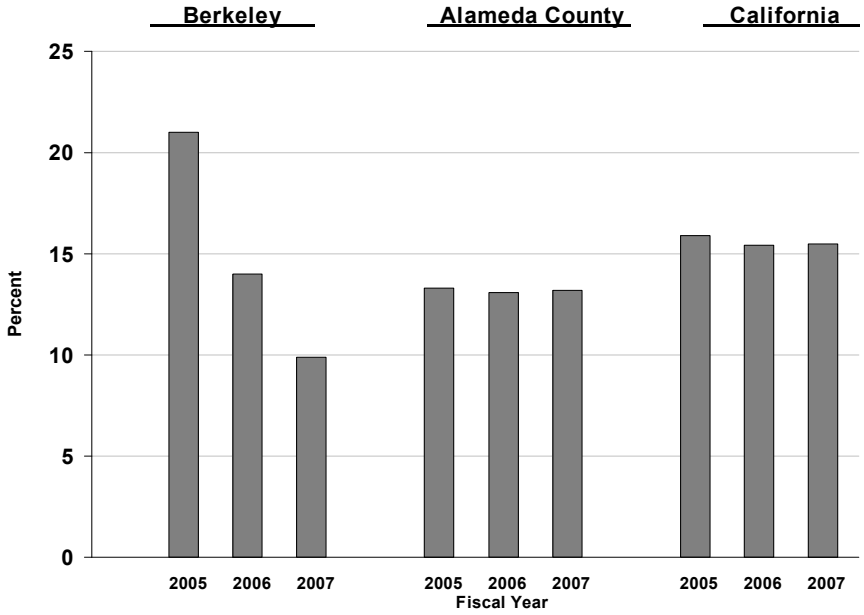

Source: PM 160 encounter forms for services rendered between July 1, 2007 and June 30, 2008

**Figure 2 . Prevalence of Overweight (≥95th%) CHDP in Berkeley, Alameda County, and California, 2005, FY2006/7, FY2007/8**



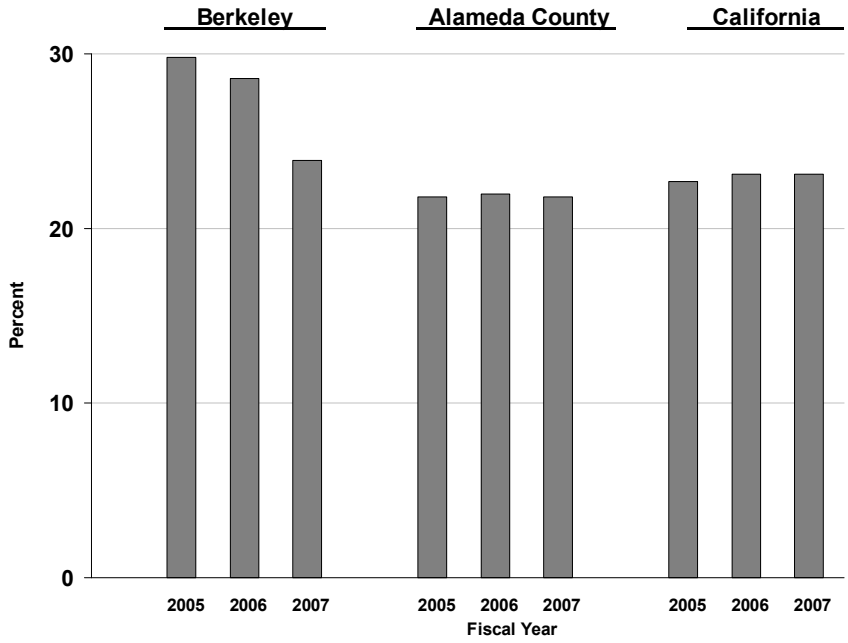

Source: California Department of Health Care Services, 2006, 2007, 2008 and PM 160 encounter forms

**Figure 3. Prevalence of Overweight (≥95th%) in 0-4 age group in CHPD of Berkeley, Alameda County, and California, 2005, FY2006/7, FY2007/8**



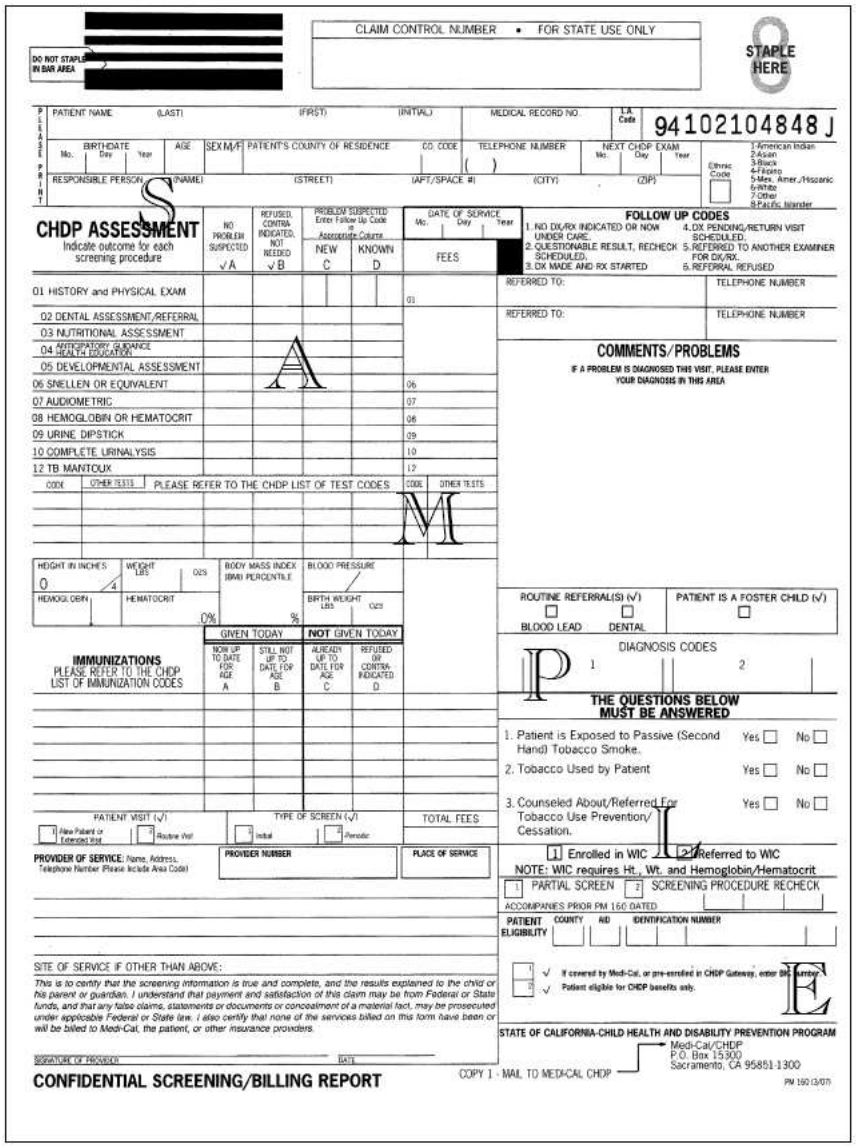

Source: California Department of Health Care Services, 2006, 2007, 2008 and PM 160 encounter forms

**Figure 4. Prevalence of Overweight (≥95th%) in 5-19 Age Group in CHDP of Berkeley, Alameda County, and California, 2005, FY2006/7, FY2007/8**




Source: California Department of Health Care Services, 2006, 2007, 2008 and PM 160 encounter forms

## Appendix. Example of a PM 160 Form



[redacted]

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. I.A. Code 94102104848 J

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year | Ethnic Code

1-American Indian 2-Asian 3-Black 4-Filipino 5-Mex. Amer./Hispanic 6-White 7-Other 8-Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT./SPACE #) (CITY) (ZIP)

S

## CHDP ASSESSMENT

Indicate outcome for each screening procedure

| | NO PROBLEM SUSPECTED √A | REFUSED, CONTRA INDICATED, NOT NEEDED √B | PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C | KNOWN D | FEES |
|---|---|---|---|---|---|
| 01 HISTORY and PHYSICAL EXAM | | | | | 01 |
| 02 DENTAL ASSESSMENT/REFERRAL | | | | | |
| 03 NUTRITIONAL ASSESSMENT | | | | | |
| 04 ANTICIPATORY GUIDANCE HEALTH EDUCATION | | | | | |
| 05 DEVELOPMENTAL ASSESSMENT | | | | | |
| 06 SNELLEN OR EQUIVALENT | | | | | 06 |
| 07 AUDIOMETRIC | | | | | 07 |
| 08 HEMOGLOBIN OR HEMATOCRIT | | | | | 08 |
| 09 URINE DIPSTICK | | | | | 09 |
| 10 COMPLETE URINALYSIS | | | | | 10 |
| 12 TB MANTOUX | | | | | 12 |

A

DATE OF SERVICE Mo. Day Year

**FOLLOW UP CODES**

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: TELEPHONE NUMBER

REFERRED TO: TELEPHONE NUMBER

**COMMENTS/PROBLEMS**

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

CODE | OTHER TESTS — PLEASE REFER TO THE CHDP LIST OF TEST CODES — CODE | OTHER TESTS

M

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT 0% | % | BIRTH WEIGHT LBS OZS

ROUTINE REFERRAL(S) (√): ☐ BLOOD LEAD ☐ DENTAL

PATIENT IS A FOSTER CHILD (√) ☐

P

DIAGNOSIS CODES 1 2

**THE QUESTIONS BELOW MUST BE ANSWERED**

| | GIVEN TODAY | | NOT GIVEN TODAY | |
|---|---|---|---|---|
| **IMMUNIZATIONS** PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES | NOW UP TO DATE FOR AGE A | STILL NOT UP TO DATE FOR AGE B | ALREADY UP TO DATE FOR AGE C | REFUSED OR CONTRA INDICATED D |

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

I

PATIENT VISIT (√): 1 New Patient or Extended Visit | 2 Routine Visit

TYPE OF SCREEN (√): 1 Initial | 2 Periodic

TOTAL FEES

PROVIDER OF SERVICE: Name, Address, Telephone Number (Please Include Area Code)

PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC 2 Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY | COUNTY | AID | IDENTIFICATION NUMBER

1 √ If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter DIC number

2 √ Patient eligible for CHDP benefits only.

E

SITE OF SERVICE IF OTHER THAN ABOVE:

*This is to certify that the screening information is true and complete, and the results explained to the child or his parent or guardian. I understand that payment and satisfaction of this claim may be from Federal or State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.*

SIGNATURE OF PROVIDER DATE

**STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM**

**CONFIDENTIAL SCREENING/BILLING REPORT**

COPY 1 - MAIL TO MEDI-CAL CHDP → Medi-Cal/CHDP P.O. Box 15300 Sacramento, CA 95851-1300

PM 160 (3/07)