

# MERGE LETTER INFORMATION

PHN: \_\_\_\_\_

Language:  English  Spanish

Fax copy of letter to WFP

Address to:  Client  Parent of Client

<b>CLIENT FIRST NAME</b>	<b>CLIENT LAST NAME</b>	
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP</b>

## REGULAR LETTERS

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> New Mother <sup>4</sup><br><input type="checkbox"/> New Child<br><input type="checkbox"/> New PNCC Client <sup>4</sup><br><input type="checkbox"/> New Baby <sup>4</sup><br><input type="checkbox"/> HMO<br><input type="checkbox"/> Missed Appointment <sup>1,2</sup><br><input type="checkbox"/> Please Call / No Phone<br><input type="checkbox"/> HIPAA Cover<br><input type="checkbox"/> CH MD <sup>5-10</sup><br><input type="checkbox"/> PNCC MD <sup>5-10</sup><br><input type="checkbox"/> PNCC MD WFP Clients <sup>1,2,5,6</sup> | <input type="checkbox"/> Brown Envelope Info <sup>3</sup><br><input type="checkbox"/> Generic Close<br><input type="checkbox"/> Probable Closure<br><input type="checkbox"/> ** Closure MD WFP Clients <sup>5,6</sup> &<br><input type="checkbox"/> <i>I was unable to locate</i><br><input type="checkbox"/> <i>client refused services</i><br><input type="checkbox"/> <i>client already being followed by Safe Babies/Healthy Families</i><br><input type="checkbox"/> Closure FAX WFP OB Pilot Program &<br><i>Home Visits Completed</i><br><input type="checkbox"/> <i>successful completion of program</i><br><input type="checkbox"/> <i>inconsistent program participation</i><br><input type="checkbox"/> <i>unable to locate</i> | <input type="checkbox"/> Standard Miscarriage<br><input type="checkbox"/> Post PNCC Thank You<br><input type="checkbox"/> Post CH Thank You<br><input type="checkbox"/> RSVP Thank You<br><input type="checkbox"/> Certified letter – After Speaking on the Phone<br><input type="checkbox"/> Certified letter – When Unable to Contact<br><input type="checkbox"/> PNCC Professional Non-Contact Visit<br><input type="checkbox"/> Inmate Fax Coversheet<br><br><p style="font-size: small;">** Closure Fax also needed for OB Pilot Program participants.</p> |
|---|--|---|

<sup>1</sup> Date Of Visit / Screening	<sup>2</sup> Time Of Visit <input type="checkbox"/> AM <input type="checkbox"/> PM	
<sup>3</sup> Information Enclosed	<sup>4</sup> Referral From	
<sup>5</sup> Client's DOB	<sup>6</sup> MD Name	<sup>7</sup> Clinic Name
<sup>8</sup> Clinic Address	<sup>9</sup> City	<sup>10</sup> Zip

## LEAD LETTERS <sup>1</sup>

- |   |  |
|---|--|
| <input type="checkbox"/> Letter #1 – Normal Lead Level (Capillary < 10)<br><input type="checkbox"/> Letter #2 – Lost Specimen<br><input type="checkbox"/> Letter #3 – Follow-up unable to reach by phone<br><input type="checkbox"/> Letter #4 – Need Confirmatory (Venous or Capillary ≥ 10)<br><input type="checkbox"/> Letter #5 – Confirmatory (Venous ≥ 20)<br><input type="checkbox"/> Letter #6 – Retest Letter (need result under 10) | <input type="checkbox"/> Letter #6a – Second Retest Letter (need another result under 10 to close case)<br><input type="checkbox"/> Letter #7 – Follow-up with Environmental Info<br><input type="checkbox"/> Letter #8 – Unable to Contact Close Lead<br><input type="checkbox"/> Letter #9 – Close Lead<br><input type="checkbox"/> Letter #10 – Need Confirmatory Venous (capillary test was between 5 and 9) |
|---|--|

<sup>1</sup> Provider <input type="checkbox"/> WIC Program <input type="checkbox"/> the Public Health Clinic <input type="checkbox"/> your Doctor's clinic Lead Level	Date of Test	Type of Test <input type="checkbox"/> C <input type="checkbox"/> V
<sup>2</sup> Retest Time Option <input type="checkbox"/> as soon as possible <input type="checkbox"/> within one month <input type="checkbox"/> within _____ months		