# Health Care Program for Children in Foster Care (HCPCFC)
# Medical Treatment Form- FAX

**Note: The information on this form provides Foster Care Public Health Nurses (FC PHN) information needed to properly follow up with the health needs of foster care children. Please fill it out carefully, legibly, and completely. Forms with incomplete documentation will be returned faxed to the clinic for further documentation. Any information that cannot be properly communicated though this form, please contact FC PHN.**

| **Child's Name:** | **Date of Exam:** |
|---|---|
| **Date of Birth:** | **Type of Visit**<br>☐ Annual CHDP/Well Child Exam<br>☐ Medical Visit<br>☐ Follow-up Exam<br>☐ Specialist Exam: _____<br>☐ Immunizations Only<br>☐ Other: _____ |
| **To**: CHDP Foster Care Nurse | |
| **Office Phone**: (805) 240-2700 | |
| ☐ **Services Offered But Refused**<br>Reason: _____<br>_____<br>_____ | |

**EXAMINATION RESULTS (To Be Completed by Medical Provider/Clinic)**

| | | | |
|---|---|---|---|
| **HT:** in | **WT:** lbs oz | **HC:** in | **Vision**: OD: / OS: / OU: /<br>☐ Glasses ☐ Contacts |
| **Hgb/ HCT:** | **BP:** **Lead:** | **BMI:** % | |

| | | |
|---|---|---|
| **Allergies**<br>☐ **NKA**<br>☐ **Yes:**_____<br>_____ | **Developmental Screening**<br>☐ Anticipatory Guidance<br>☐ ASQ<br>☐ PEDS<br>☐ MCHAT<br>☐ Other: _____<br>☐ Referral: _____<br>☐ No Problems Noted | **Hearing**: ☐ Pass ☐ Fail<br>☐ Hearing Aide<br><br>**Behavioral Health**<br>Diagnosis: _____<br>_____<br>_____<br>☐ Psychotropic Medications<br>☐ JV220 initiated/ completed<br>☐ Referred to: _____<br>☐ No Problems Noted |
| **TB Skin Test**: **Y** or **N**<br>Date Given: _____<br>Date Read: _____<br>Induration: ____ mm<br>Result: _____ | | |

**Immunizations**

| | | | | |
|---|---|---|---|---|
| ☐ DTaP/ Tdap | ☐ Hep A | ☐ Hep B | ☐ Hib | ☐ HPV |
| ☐ Influenza | ☐ IPV | ☐ MCV4 | ☐ MMR | ☐ PCV13/PPSV23 |
| ☐ Rotavirus | ☐ Synagis | ☐ VAR | ☐ Other: | |

| Diagnosis | New | Known | Services Provided | Plan (Medications/Follow-Up) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

| | |
|---|---|
| **Name of Provider:**<br>**Address:**<br>**Clinic Phone:**<br><br>**Provider Signature: _____**<br>**Date: _____** | *****HEALTH CARE PROVIDERS:*****<br>Please complete the form and FAX within 48 hours to the CHDP Nurse at **(805)240-2710**. Medical provider keeps original, faxes copy to CHDP Foster Care Nurse, and gives two copies to Substitute Care Provider. Any questions please contact Foster Care Nurse at **(805)240-2700**. |

**Please attach any supporting documents**

# Health Care Program for Children in Foster Care (HCPCFC)
# Dental Treatment Form- FAX

**Note:** **The information on this form provides Foster Care Public Health Nurses (FC PHNs) information needed to properly follow up with the health needs of foster care children. Please fill it out carefully, legibly, and completely. Forms with incomplete documentation will be returned faxed to the clinic for further documentation. Any information that cannot be properly communicated though this form, please contact FC PHN.**

| **Child's Name:** | **Date of Exam**: |
|---|---|
| **Date of Birth:** | **Type of Visit** |
| **To**: CHDP Foster Care Nurse | ☐ Emergency Dental Visit |
| **Office Phone**: (805) 240-2700 | ☐ Initial Dental Examination |
| ☐ **Services Offered But Refused** | ☐ Semi Annual Dental Examination |
| Reason: _____ | ☐ Orthodontic |
| _____ | ☐ Other: _____ |
| _____ | |

**Services Provided THIS date (To Be Completed Dental Provider)**

| ☐ **Exam** | ☐ **X-Rays** | ☐ **Cleaning** | ☐ **Fluoride Varnish** | ☐**Other: Please list:** _____ |
|---|---|---|---|---|
| | | | | |

**Is further dental treatment needed?_____ Is another appointment already scheduled?___**

**How many appointments will be needed to complete recommended treatment?_____**

**Is referral to a specialist required? _____ If so, which type of specialist? _____**

**Has the child an appointment already scheduled with specialist? _____**

**If so, Name and phone specialist_____**

**Does child need only regular semi annual dental visits at this time?_____**

| **Name of Provider:**<br>**Address:**<br>**Clinic Phone:**<br><br><br>**Provider Signature: _____**<br>**Date: _____** | *****DENTAL PROVIDERS:*****<br>Please complete the form and FAX within 48 hours to the CHDP Nurse at **(805)240-2710**. Medical provider keeps original, faxes copy to CHDP Foster Care Nurse, and gives two copies to Substitute Care Provider. Any questions please contact Foster Care Nurse at **(805)240-2700**. |
|---|---|

**Please attach any supporting documents**