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** ☐ Annual CHDP/Well Child Exam ☐ Medical Visit ☐ Follow-up Exam ☐ Specialist Exam: _____ ☐ Immunizations Only ☐ Other: _____
To: CHDP Foster Care Nurse	
Office Phone: (805) 240-2700	
☐ **Services Offered But Refused** Reason: _____ _____ _____	

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

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

Allergies ☐ **NKA** ☐ **Yes:**_____ _____	**Developmental Screening** ☐ Anticipatory Guidance ☐ ASQ ☐ PEDS ☐ MCHAT ☐ Other: _____ ☐ Referral: _____ ☐ No Problems Noted	**Hearing**: ☐ Pass ☐ Fail ☐ Hearing Aide **Behavioral Health** Diagnosis: _____ _____ _____ ☐ Psychotropic Medications ☐ JV220 initiated/ completed ☐ Referred to: _____ ☐ No Problems Noted
TB Skin Test: **Y** or **N** Date Given: _____ Date Read: _____ Induration: ____ mm 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: **Address:** **Clinic Phone:** **Provider Signature: _____** **Date: _____**	*****HEALTH CARE PROVIDERS:***** 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: **Address:** **Clinic Phone:** **Provider Signature: _____** **Date: _____**	*****DENTAL PROVIDERS:***** 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