

Health Care Program for Children in Foster Care (HCPCFC) Foster Care Medical (Specialty) Contact Form

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system.

Patient Name (Last)			(First)			(Initial)			Language			Date of Service Month Day Year									
Birthdate Month Day Year		Age (yr/m)	Sex	Gender	Patient's County of Residence			Telephone # (Home or Cell)			Alternate Phone # (Work or Other)										
Responsible Person (Name)										(Street)			(Apt/Space)			(City)			(Zip)		
Patient Eligibility:		County Code	Aid Code	Identification Number						Next CHDP Exam Month Day Year			Ethnic Code <input type="checkbox"/>			1-White 2-Hispanic/Latino 3-Black/African American 4-American Indian/Alaska Native 5-Asian 6-Native Hawaiian/Other Pacific Islander 7-Other					

A. Medical Assessment and Referral Section

Type of Visit:		MEDICAL <input type="checkbox"/> Well Child Exam <input type="checkbox"/> Immunization Visit <input type="checkbox"/> Sick Visit/Urgent Care <input type="checkbox"/> Reproductive Health <input type="checkbox"/> Follow Up									
		SPECIALTY <input type="checkbox"/> Initial Consultation <input type="checkbox"/> Follow Up									
Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health)											
Height To nearest 0.1 cm	Height Percentile	Weight To nearest 0.1 kg	Weight Percentile	BMI	BMI Percentile	Head Circumference	Head Circ. Percentile	IMMUNIZATIONS <input type="checkbox"/> Copy of IZ Records Attached? Please check (<input checked="" type="checkbox"/>) which immunizations have been given TODAY: IPV 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> DTaP 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Td <input type="checkbox"/> Tdap/Booster <input type="checkbox"/> Hib 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> MMR 1 <input type="checkbox"/> 2 <input type="checkbox"/> Hep B 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Hep A 1 <input type="checkbox"/> 2 <input type="checkbox"/> VZV 1 <input type="checkbox"/> 2 <input type="checkbox"/> PCV 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> PCV13 <input type="checkbox"/> MenACWY <input type="checkbox"/> HPV 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Influenza 1 <input type="checkbox"/> 2 <input type="checkbox"/> Rotavirus 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Up to date <input type="checkbox"/> Not up to date <input type="checkbox"/> PPD <input type="checkbox"/> TB Risk Assessment Date Given: _____ Date Read: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Return for PPD Read <input type="checkbox"/> Lab ordered for QFT/IGRA			
Blood Pressure	Hemoglobin	Hematocrit	Vision Results OD OS OU			Hearing Results R L					
Labs Ordered <input type="checkbox"/> CBC <input type="checkbox"/> Lead <input type="checkbox"/> Other: _____			Date Labs Ordered	Lab Results							
Any known allergies to medication/food/environment? <input type="checkbox"/> Y <input type="checkbox"/> N Please list: _____											
ASSESSMENT/DIAGNOSIS: Depression Screening: <input type="checkbox"/> Y <input type="checkbox"/> N Substance Abuse Screening: <input type="checkbox"/> Y <input type="checkbox"/> N Tool Used (if any?): _____											
MEDICATIONS/TREATMENTS: (DOSAGE/FREQUENCY)								If prescribed psychotropic medication was a JV220 (A) completed? <input type="checkbox"/> Y <input type="checkbox"/> N Was EKG completed? <input type="checkbox"/> Y <input type="checkbox"/> N Were Labs completed? <input type="checkbox"/> Y <input type="checkbox"/> N			
DEVELOPMENTAL SCREENING/ASSESSMENT: Completed today? <input type="checkbox"/> Y <input type="checkbox"/> N Developmental tool used, if any: (Please attach a copy) <input type="checkbox"/> ASQ-3 <input type="checkbox"/> ASQ-SE <input type="checkbox"/> Other (Specify): _____ Age appropriate development? <input type="checkbox"/> Y <input type="checkbox"/> N if NO, Indicate: <input type="checkbox"/> Gross <input type="checkbox"/> Fine <input type="checkbox"/> Speech/Language <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Cognitive Physical Growth <input type="checkbox"/> WNL <input type="checkbox"/> Delayed											
REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)											

B. Dental Assessment and Referral Section

<input type="checkbox"/> Class I: No Visible Problems Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)	<input type="checkbox"/> Class II: Visible decay, small carious lesion or gingivitis Needs non-urgent dental care	<input type="checkbox"/> Class III: Urgent – pain, abscess, large carious lesions or extensive gingivitis Immediate treatment for urgent dental condition which can progress rapidly	<input type="checkbox"/> Class IV: Emergent – acute injury, oral infection or other pain Needs immediate dental treatment within 24 hours
Fluoride Varnish Applied: <input type="checkbox"/> Yes <input type="checkbox"/> No, parent refused <input type="checkbox"/> No, teeth have not erupted <input type="checkbox"/> Other reason for not applying: _____			
<input type="checkbox"/> Dental home referral Referred To and Contact Number: _____			

C. Provider Information

Service Location: Office Name, Address, Telephone/Fax Number		NPI Number	
		Provider Name (Print Name)	
		Provider Signature	Date
Follow up appointments needed? <input type="checkbox"/> Y <input type="checkbox"/> N Date/Time _____			