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			Age(yr/m) Sex (ender Patient's County		v of Residence	Telephone # (Ho	ome or Cell)	Alternate Phone #	Phone # (Work or Other)	
Month Day		rear								Alternate i none # (Work of Other)		
Responsible Person (Name) (Street) (Apt/Space) (City) (Zip) 1-White												
Ethnic 3-Black/African American												
											Indian/Alaska Native	
Patient	Со	unty Code	Aid Code	Identification Nurr	entification Number			Next CHDP Exam Month Day Year		5-Asian 6-Native Hawaiian/Other Pacific Islander		
Eligibility	y:											
A. Me	dical A	ssessm	ent and F	Referral Section	nn					7-Other		
MEDICAL Well Child Exam Immunization Visit Sick Visit/Urgent Care Reproductive Health Follow Up												
Туре								□ Initial Consultation □ Follow Up				
Visit	:	JFL			a Ontometry Neuro	ology, Cardiology, Audic	Nogy Mental Health)					
Heigh	ht	Heig	ht	Weight	Weight	BMI	BMI Percentile	Head	Head Circ.	IMMUNIZATIONS		
To nearest 0.1 cm Blood Pressure		Percentile		To nearest 0.1 kg	Percentile	e		Circumference	Percentile	☐ Copy of IZ Records Attached? Please check (☑) which immunizations have been given		
						Vision Result		Hearing	Deculto			
				Hematocrit	OD	OS	OU	R	Hearing Results R L		TODAY:	
Laba Ord	darad				Date Labs Ordered Lab Res					IPV 1□ 2□ DTaP 1□ 2□		
Labs Ordered Date Labs Ordered Lab Results CBC Lead Other:										DTaP 1□ 2□ 3□ 4□ 5□ Td □		
Any known allergies to medication/food/environment?												
MMR 1□ 2□ Hep B 1□ 2□ 3□												
MEDICATIONS/TREATMENTS:												
(DOSAGE/FREQUENCY) medication was a POUL AND THE ADDRESS AND T												
	JV220 (A) completed? □Y □N MenACWY □ Was EKG completed? □Y □N HPV 1□ 2□ 3□											
Were Labs completed? Y N Influenza 1 2												
DEVELOPMENTAL SCREENING/ASSESSMENT: Completed today? Y N Other:												
Developmental tool used, if any: (Please attach a copy) ASQ-3 ASQ-SE Other (Specify):												
	Age appropriate development? Y N if NO, Indicate: Gross Fine Speech/Language Social/Emotional Cognitive											
Physical Growth WNL Delayed												
										Date Read:		
REFERR	AL5: (e.	g. Mental He	ealth, CCS, S	peech and Hearing,	IEP)						Results: Negative Positive	
										□ Return for PPD Read □ Lab ordered for QFT/IGRA		
B. Dental Assessment and Referral Section												
Class					ass II: Visible	decay, small	Class III: U	rgent – pain, abso	ess, I 🗆 C	lass IV: Emergent –	acute injury,	
	Mandated annual routine dental			parious logion or gingivitio			large cariou	s lesions or extens		oral infection or other pain		
referral (beginning no later th and recommended every 6 r					eeds non-urgent dental care		gingivitis		N	Needs immediate dental treatment		
			ry 6 month	s)			Immediate treatment for urgent dental			within 24 hours		
							condition w	hich can progress i	rapidly			
Fluoride Varnish Applied: Yes No, parent refused No, tee								n have not erupted				
Other reason for not applying:												
□ Dental home referral Referred To and												
☐ 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)				
								Dravidar Signatura Data				
								Provider Signat	ure		Date	
Follow up appointments needed? Y N Date/Time												