Medical Examination Form

General Information. Caregiver or Case worker must complete this section. Please print legibly.

_______________________________________ _______________ ______________ ___________
Child's Name DOB Client # Date

Allergies: ____ None Known ____ Yes (list): ____

Caregiver's Name:____ Phone #:__________________

____ ________________ __________ ________
Address City State Zip

_________________________________ __________________________ _________________
CPS Case Worker Phone Fax

Reason for Visit (select one).

☐ WELL CHILD Examination (specify type of visit)

☐ **INITIAL Texas Health Steps Medical Checkup by a TX Health Steps provider 30 days of entering DFPS Conservatorship.**

☐ Child UNDER AGE 36 Months needs additional age-appropriate TX Heath Steps Medical Checkup per Periodicity Schedule (3 to 5 days after birth, 2 weeks after birth 2,4,6,9,12,15,18,24 and 30).

☐ Child AGE 36 MONTHS or OLDER needs additional age-appropriate TX Health Steps Medical checkup annually.

☐ Child with Primary Medical Needs (PMN) (must have medical examination within 7 days before or 3 days of placement and every 90-days thereafter or on a schedule recommended by the child's physician.

☐ **Vision Checkup** ☐ **Hearing Checkup**

☐ **Dental Checkup**

☐ Child Age 6 Months or Older needs an INITIAL TX Health Steps Dental Checkup by a TX Health Steps provider within 60 days of entering DFPS conservatorship.

☐ Child UNDER AGE 6 Months upon entry into DFPS conservatorship needs an initial TX Health Steps Dental Check up by a TX Health Steps provider within 30 days of becoming age 6 months

☐ ADDITIONAL 6 MONTH TX Health Steps Dental Checkup (Dental checkups every 6 months thereafter, or as recommended by the TX Health Steps provider.

☐ **PSYCHIATRIC APPOINTMENT**

☐ Evaluation ☐ Medication Review ☐ Lab: ___________________________

☐ **ILLNESS/INJURY/ACCIDENT**- Initial or Follow-up reason for child's need to see a health care provider.

☐ INITIAL DATE of incident/illness: ______________________ Time _________ am / pm

DESCRIBE illness/injury ____

____

____Follow-up needed? DATE of Follow-up: ________________ Time: ______ am / pm

☐ **SPECIALIST** needed. Child needs to be seen by a specialist. Provide information below:

Specialty	Physician's Name	Reason

HEALTH CARE EXAMINATION (Health Care Provider must complete this section.)

____ ____________________________

HEALTH CARE PROVIDER'S NAME **EXAMINATION DATE**

☐ **YES** ☐ **NO** **Are you a Texas Health Steps provider?**

☐ **YES** ☐ **NO** **Was the child tested for lead poisoning?**

☐ **YES** ☐ **NO** **Did child receive TB screening Date read: _____________ Result ___________**

TYPE OF VISIT (check all that apply)

MEDICAL

☐ **INITIAL TX Health Steps Medical Checkup Procedures: __________________________________**

☐ **Annual/Age-appropriate TX Health Steps Medical Checkup Procedures: __________________________________**

☐ **OTHER recommended Medical Checkup Procedures: __________________________________**

☐ **ER Visit Procedures: __________________________________**

☐ **Acute Care / Follow-up visit Procedures: __________________________________**

<u>Physical Exam Results:</u> Complete below or attach a copy of your medical record or the TX Health Steps form

Age: ________________________________ Height: _________________ %:______________

Years/Months/Weeks Weight: _________________ %: ______________

Temperature: _________ Pulse: _________ Respirations: __________ Blood Pressure ________

☐ Child refused the examination Comments: ____

Hearing & Vision

Hearing

	500	1000	2000	4000
Right ear				
Left ear				

☐ Not Done ☐ Too many prompts ☐ Refused

Vision

R 20/______ L 20/______ ☐ Not Done ☐ Too many prompts ☐ Refused

☐ Glasses ☐ No glasses ☐ Did not bring glasses

Dental

☐ **INITIAL TX Health Steps Dental Checkup** **Procedures:** ____________________________________

☐ **Six-month TX Health Steps Dental Checkup** **Procedures:** ____________________________________

☐ **OTHER recommended Dental Checkup** **Procedures:** ____________________________________

Psychiatric Appointment

☐ Evaluation ☐ Medication Review ☐ Lab: ____

Referrals

☐ **Early Childhood Intervention** ☐ **Speech Therapy**

☐ **Physical Therapy** ☐ **Occupational Therapy**

☐ **Mental Health** ☐ **Alcohol & Drug Screening**

☐ **Specialist** **As specified:** ____

☐ **Diagnostic Assessment/s, if necessary:** ____

☐ **Other, as specified:** ____

Current Medication and Medication Changes
Please list all current medications

No Medication Changes

Stopped	New	Changes	OTC Contra Indicated	Medication	Dosage	Prescribed for	Instructions, if any

☐ **OTC Contraindications with medications listed above:** ______________________________________
____

☐ Procedures: ☐ Developmental Screen ☐ Autism Screen ☐ Hemoglobin ☐ Blood Lead Test ☐ Other (list):
____
____

☐ **Diagnosis/Test result**: ____
____

☐ **Recommended Follow-Up, Appointments Schedule**: ☐ None Necessary ☐ Next Well Child
Return Visit: When:
Why:

Immunizations
If appropriate, complete immunization record & give record to Caregiver

________________________ ________________________ ________________________
________________________ ________________________ ________________________

For PMN Treatment Service Only: To be completed by the treating healthcare provider
Does the child require additional medical treatment/service? ☐ Yes ☐ No if "yes" attach the changed physician order.
Can the child continue to be cared for appropriately in the current foster home? ☐ Yes ☐ No if "no" explain:
____
____

____ ____
Signature of Health Care Provider Address

____ ____
Printed Name of Health Care Provider City, State, Zip Code

____ ____
Signature of Caregiver (if completed by caregiver) Health Care Provider Phone#