

NAPA COUNTY HEALTH AND HUMAN SERVICES AGENCY

CHDP/Health Care Program for Children in Foster Care

2751 Napa Valley Corporate Drive, Napa, CA 94558

Phone: (707) 259-8723 Fax: (707) 299-4496

HEALTH CONTACT FORM

DATE OF EXAM: _____

Please complete this form for every medical, dental and specialty visit (including CHDP examination).

SECTION A (Completed by Substitute Care Provider)

Child's Name: _____ DOB: _____

Social Worker /Probation Officer _____ Phone No: _____

Foster parent/Group home: _____ Phone No: _____

Doctor/Dentist: _____ Phone No: _____

Doctor/Dentist Address: _____ Phone No: _____

SECTION B (Completed by Health Care Provider or Substitute Care Provider)

TYPE OF VISIT

<u>MEDICAL</u>	<u>DENTAL</u>	<u>SPECIALIST HEALTH/DDS THIS VISIT</u>
<input type="checkbox"/> CHDP Physical <input type="checkbox"/> Routine Well Child Exam <input type="checkbox"/> Sick Visit/Urgent Care <input type="checkbox"/> Follow-Up <input type="checkbox"/> Immunizations only visit	<input type="checkbox"/> Exam & Cleaning <input type="checkbox"/> Treatment <input type="checkbox"/> Follow-Up <input type="checkbox"/> Oral surgery <input type="checkbox"/> Root Canal	<input type="checkbox"/> Type _____ <input type="checkbox"/> Follow-Up _____
Height: _____ (_____ %)	Vision: Rt: _____ Lt: _____	Hgb/Hct: _____
Weight: _____ (_____ %)	Hearing: Rt: _____ Lt: _____	Lead: _____
Head Cir: _____ (_____ %)		
<u>DIAGNOSIS/ TREATMENTS/ MEDICATIONS(with dose):</u>		<u>IMMUNIZATIONS:</u>
		IPV, OPV 1__ 2__ 3__ 4__ 5__ DTP, DTAP, TDAP 1__ 2__ 3__ 4__ 5__ HIB 1__ 2__ 3__ 4__ HEP B 1__ 2__ 3__ MMR 1__ 2__ VARICELLA 1__ 2__ HEP A 1__ 2__ PPD 1__ Results: <input type="checkbox"/> Neg <input type="checkbox"/> Pos MENACTRA: _____ HPV: _____ INFLUENZA/ H1N1 _____ PNEUMOCOCCAL _____ ROTAVIRUS _____ OTHER _____
<u>DEVELOPMENTAL ASSESSMENT:</u>		<u>REFERRALS MADE:</u>
Normal _____ Abnormal: _____ (Explain)		

FOLLOW-UP APPOINTMENT SCHEDULED: Y N Date: _____ What is follow up for? _____

HEALTH CARE PROVIDER SIGNATURE: _____

Please MAIL completed form to address at top of this page, GIVE to SW/PO or FAX to (707) 299-4496. Thank You

Distribution: **White copy-** Public Health Nurse and Social Worker/Probation Officer **Yellow copy-** Foster/Group Home