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| **COMPLETE FOR ANY HEALTH CARE VISIT** |
| Date of Visit:      | Type of Visit (check one): [ ]  Medical [ ]  Dental [ ]  Mental Health [ ]  Well Child Exam [ ]  Sick Visit [ ]  Follow-up Visit[ ]  Other: (Please specify):       |
| Social Worker LAST NAME:      | Social Worker FIRST Name:      | SW E-mail:      | SW Phone:      |
| DCF Office:      | SW Fax:      |
| Child LAST Name:      | Child FIRST Name:      | DOB:       | Gender:      |
| Child’s Age:      | Primary Language:      | Case ID #:      | Person ID #:      |
| **PROVIDER** |
| Growth: | Height:     ‘ |      “ | Weight:       Lbs. | BMI:      | HC:      |
| Diagnosis:      |
| Lab work / Tests ordered? [ ]  Yes [ ]  No. If yes, please explain:      |
| Immunizations Given? [ ]  Yes [ ]  No. If yes, please list:      | **Attach a copy of completed immunization record** |
| Findings / Comments:      |
| Recommendations / Treatment / Medication:      |
| Referral to Specialist? [ ]  Yes [ ]  No. If yes, please indicate the name of the specialist and the reason for referral:      |
| Follow-up needed? [ ]  Yes [ ]  No. If yes, please indicate Date of Next Appointment:      |
| Provider Name       | Provider E-mail:      | Provider Phone:      | Provider Fax:      |
| Provider Address (No. and Street)      | Apt/Suite. #:      | City:      | State:      | Zip:      |
| **[ ]  I Need to Speak with a Social Worker** | Best method to contact:      | E-mail:      | Phone:      |