`STATE OF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES

Medical Questionnaire/Request for Information

To:	HEALTH CARE PROVIDER	DATE
	ADDRESS	FAX

From:	DCF WORKER	TELEPHONE
	AREA OFFICE	FAX

The Department of Children and Families has a request for a Probate Court study concerning the family of the child listed below. In accordance with our policies, we are requesting information that would become part of the confidential file. Enclosed is a signed authorization to release information from your records. We ask that you take a moment to complete this form and return it to us **within two weeks**. Thank you for your anticipated assistance in this matter.

Family or Custodial Parent's Name:			
Child/Youth:		DOB:	
Date of Last Physical:		HT: WT: BMI:	
How long has the child been a patient in your practice? years			
Has child been seen elsewhere for medical care? If so, where?		NAME OF PROVIDER:	
Is the patient up to date with immunizations and well child visits?	☐ YES ☐ NO	IF NO, WHAT IS NEEDED?	
Has child had lead level checked?	☐ YES ☐ NO	IF YES, DATE:	LEVEL:
Are there any identified medical or dental problems?	☐ YES ☐ NO	IF YES, PLEASE EXPLAIN:	
Are there any developmental, behavioral, or mental health concerns?	☐ YES ☐ NO	IF YES, PLEASE EXPLAIN CONCERN AND ANY SPECIALIST REFERRALS MADE:	
If the patient is less than three (3) years of age would this patient benefit from a referral of **Birth to Three Services**?	☐ YES ☐ NO	If YES, was a referral made to **Birth to Three**? ☐ YES ☐ NO ☐ Check here if patient already involved with **Birth to Three**	

Is the child presently on any medication?	☐ YES ☐ NO	IF YES, PLEASE LIST MEDICATION AND WHAT IT IS PRESCRIBED FOR:	
List any specialist referrals made and dates:		NAME OF SPECIALIST:	DATE OF REFERRAL:
Any missed appointments/ pattern of missed appointments or other concerns you would like to discuss with the DCF worker?			

Health Care Provider's Signature:		Date:	

☐ **Need to speak with Social Worker**	BEST DAYS AND TIMES TO CONTACT: Days: _____ Times: _____ Telephone: _____

Please attach a copy of: ☐ Immunization records

☐ Last physical exam

Fax to:

Fax #

PLEASE RETURN WITHIN TWO WEEKS