MEDICAL, DENTAL, VISION, HEARING, OR BEHAVIORAL HEALTH APPOINTMENT

Purpose: Use this form to document medical, dental, vision, hearing and behavioral health (Child and Adolescent Needs and Strengths assessment (CANS)) appointments.

Completion of this form meets requirements in:

- Residential Child Care Licensing Minimum Standards
- Residential Child Care Contracts
- Child Protective Services policy

Completion of this form is not required for allied health services such as physical therapy, occupational therapy, speech therapy, or dietary services.

Directions: The person taking the child or youth completes Section I of this form on each visit with a health care provider. When possible, Section II is completed by the health care provider.

If the health care provider is unable to complete Section II, the person taking the child or youth to the appointment completes Section II, signs his or her name, and checks the box labeled: *health care provider unable to complete*. The health care provider may attach medical records or other information to this form in lieu of completing Section II.

The caregiver provides a copy of the completed form to the CPS caseworker to file in the case record.

SECTION I. **CHILD'S INFORMATION**			
Child's or Youth's Name:	Date of Birth:	Person Identification (PID) Number:	Appointment Date:

CAREGIVER INFORMATION **Caregiver can be a foster parent, relative, non-relative, or representative of a residential operation who is taking the child to the health care provider.**			
Caregiver's Name:	Phone:	Agency:	
Address:	City:	State:	Zip:

CPS CASEWORKER INFORMATION		
Caseworker's Name:	Phone:	Fax:

REASON FOR VISIT

☐ **3-Day Medical Exam.** (Required within three business days of removal with some exceptions, such as DFPS removal while child is in a hospital setting).

☐ **Child or Youth with Primary Medical Needs.** (Required within seven days before or three days after placement date).

☐ **Initial Child and Adolescent Needs and Strengths (CANS) Assessment.** (Required within 30 days of entering DFPS conservatorship).

☐ **Child and Adolescent Needs and Strengths Update (CANS) Assessment.** (Required annually; may be required more frequently in some areas).

☐ **Initial Texas Health Steps Medical Checkup.** (Required within 30 days of entering DFPS conservatorship).

☐ **Routine Texas Health Steps Medical Checkup.** (Required at the following ages: within five days after discharge from the hospital, at 2 weeks of age, at 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 36 months, and then annually).

☐ **Other Medical Checkup.** Reason:

☐ **Initial Texas Health Steps Dental Checkup.** (Required within 60 days of entering DFPS conservatorship if the child is 6 months of age or older, or within 30 days of turning age 6 months).

☐ **Routine Texas Health Steps Dental Checkup.** (Required every six months or as recommended by a dentist).

☐ **Other Dental Checkup.** Reason:

☐ **Vision Check.** ☐ **Hearing Check.**

☐ **ER Visit.**– Reason:

☐ **Specialty Visit.** – Reason:

☐ **Illness, injury or accident or other follow-up visit.** (Describe the injury, accident or illness, including the date and time of the incident.)

MEDICATIONS

☐ No ☐ Yes (List):

Medication	Dosage	Prescribed for	Instructions

Caregiver Comments:			

SIGNATURE OF PERSON COMPLETING SECTION I	
DFPS Staff or Caregiver Signature: X	Date Signed:

SECTION II. HEALTH CARE APPOINTMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)		
Child or Youth's Name:	Date of Birth:	Appointment Date:

VISIT RESULTS

☐ Child or Youth Refused Appointment

VITALS:

Years:	Months:	Weeks:	Temperature:	Pulse:	Respirations:	Blood Pressure:

Height: %:	Weight: %:	Head Circumference: %:	BMI: %:

VISION SCREEN:

☐ Not Done ☐ Child or youth unable to comply with screening ☐ Refused

R 20/	L 20/	☐ No Glasses ☐ Glasses ☐ Did not bring Glasses

HEARING SCREEN:

☐ Not Done ☐ Child or youth unable to comply with screening ☐ Refused

	500	1000	2000	4000
R				

L				

PROCEDURES OR TESTS:

☐ None ☐ TB Screen ☐ Lead Screen ☐ Developmental Screen ☐ Autism Screen ☐ Hemoglobin ☐ PPD

☐ Blood Lead Test ☐ Other (list):

DIAGNOSES:

☐ Well Child or No Dental Problems ☐ Other (list):

NEW OR CHANGED MEDICATIONS ONLY:

☐ No Medication Changes

Name	Dosage	Prescribed for	Instructions	Discontinued	New	Changed
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

VACCINES

Children and youth are prohibited from receiving vaccinations at the 3-Day Medical Exam unless an emergency situation requires tetanus vaccination.

☐ None Administered

☐ DTap ☐ DT ☐ Tdap ☐ HIB ☐ PCV ☐ Td ☐ MMR ☐ Varicella ☐ Hep A ☐ Hep B ☐ IPV ☐ HPV ☐ MCV

☐ Rotavirus ☐ Influenza ☐ Pneumovax ☐ Other (list):

REFFERRED TO:

☐ None Necessary

☐ ECI (Early Childhood Intervention) ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

☐ Specialist (Type):	☐ Other (Type)

FOLLOW-UP:

☐ None Necessary
☐ Return Visit: When and Why
Provider Comments:

PROVIDER INFORMATION

Provider Signature: X	Clinic Name:	Phone:
Printed Name:	Address:	Fax:
Date Signed:	City, State, Zip	

CAREGIVER

If section II is not completed by a medical or dental provider, the caregiver signs below.

Caregiver Signature X ☐ *The health care provider was unable to complete this form.*	Date: