Medical and Dental Treatment Form
FAX

Health Care Provider: Please complete the form below and FAX within 48 hours to the CHDP Nurse at (805) 240-2710. The substitute care provider should be provided with two copies.

To: CHDP Foster Care Nurse	**Name of Provider**:
Office Phone: (805) 240-2700	**Clinic Phone**:
Child's Name:	
Date of Birth:	**Date of Exam**:

Type of Visit:

☐ Annual CHDP/Well Child Exam ☐ Medical Visit ☐ Other
☐ Semi-Annual Dental Exam ☐ Dental Visit

EXAMINATION RESULTS (To Be Completed by Medical or Dental Provider)

Height:	Weight:	HC:	BP:	BMI %:
HGB/HCT:	Lead Screen:	Hearing:	Vision:	
TB Skin Test: Date given		Result:	mm Induration	
☐ DTaP	☐ Hep B	☐ Hep A	☐ MMR	☐ Varicella
☐ Tdap	☐ Pediarix	☐ Prevnar PVC	☐ MCV4	☐ Penatacel
☐ HPV	☐ Other			

Diagnosis:_____	Plan/Treatment:_____
	Date return visit:

Was child referred to another provider? ☐ *Yes/Specialty*_____
*Name of Specialist:*_____ *Telephone:*_____

Provider Signature:_____ Date: _____
(or Designee)

(Required Information) Clinic/Provider:_____ Address:_____ City:_____ Phone:	**Provider Stamp**

NOTE: Medical Provider keeps original, faxes to CHDP Foster Care Nurse at (805) 240-2710, and gives 2 copies to Substitute Care Provider.

White: Medical provider/FAX to CHDP Foster Care Nurse ***Yellow & Pink: Substitute Care Provider***