

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.

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|-------------------------------------|--------------------------|
| 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:

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Annual CHDP/Well Child Exam | <input type="checkbox"/> Medical Visit | <input type="checkbox"/> Other |
| <input type="checkbox"/> Semi-Annual Dental Exam | <input type="checkbox"/> Dental Visit | |

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

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|-------------------------------|-----------------------------------|--------------------------------------|-------------------------------|------------------------------------|
| Height: | Weight: | HC: | BP: | BMI %: |
| HGB/HCT: | Lead Screen: | Hearing: | Vision: | |
| TB Skin Test: Date given | | Result: | mm Induration | |
| <input type="checkbox"/> DTaP | <input type="checkbox"/> Hep B | <input type="checkbox"/> Hep A | <input type="checkbox"/> MMR | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Tdap | <input type="checkbox"/> Pediarix | <input type="checkbox"/> Prevnar PVC | <input type="checkbox"/> MCV4 | <input type="checkbox"/> Penatacel |
| <input type="checkbox"/> HPV | <input type="checkbox"/> 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