

Medical Examination Form

I. GENERAL INFORMATION (this section to be completed by Caregiver or Caseworker. Please print legibly.)

Child's Name	DOB	PID #	DATE
Caregiver's Name: _____		Phone #: _____	
Address	City	State	Zip
CPS CW: _____	Phone #: _____	Fax #: _____	

REASON FOR VISIT (select one)

WELL CHILD Examination (specify what type)

INITIAL Texas Health Steps Medical Checkup by a TX Health Steps provider-30 days of entering DFPS Conservatorship

Child UNDER AGE 36 MONTHS needs additional age-appropriate TX Health Steps Medical Checkup per Periodicity Schedule (3 to 5 days after birth, 2 weeks after birth, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months)

Child AGE 36 MONTHS or OLDER needs additional age-appropriate TX Health Steps Medical Checkup annually

Child with Primary Medical Needs (PMN) (needs a medical examination within 7 days before or 3 days of placement)

VISION Checkup

HEARING Checkup

DENTAL Checkup (specify what type)

Child AGE 6 MONTHS or OLDER needs an INITIAL TX Health Steps Dental Checkup by a TX Health Steps provider within 60 days of entering DFPS conservatorship.

Child UNDER AGE 6 MONTHS upon entry into DFPS conservatorship needs an initial TX Health Steps Dental Checkup by a TX Health Steps provider within 30 days of becoming age 6 months.

ADDITIONAL 6 MONTH TX Health Steps Dental Checkup (Dental checkups every 6 months thereafter, or as recommended by the TX Health Steps provider – FC 10.03(b))

PSYCHIATRIC APPOINTMENT

Evaluation Medication Review Lab: _____

ILLNESS / INJURY / ACCIDENT – Initial or Follow-up reason for child's need to see a health care provider

INITIAL DATE of incident/illness: _____ TIME: _____ am / pm

DESCRIBE injury/illness: _____

FOLLOW-UP needed? DATE of Follow-up: _____ TIME: _____ am / pm

SPECIALIST needed – child needs to be seen by a specialist? Please specify: _____

Specialty	Physician's Name	Reason	Specialty	Physician Name	Reason

Signature of Caregiver, Arrow staff, or DFPS staff	Date
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Medical Examination Form

II. HEALTH CARE EXAMINATION (this section to be completed by Health Care Provider.)

HEALTH CARE PROVIDER'S NAME _____

EXAMINATION DATE _____

Yes No Are you a Texas Health Steps provider?

Yes No Was child tested for lead poisoning?

Yes No Did child receive TB screening? Date read: _____ Results: _____

TYPE OF VISIT (check all that apply)

MEDICAL

- | | |
|---|-------------------|
| <input type="checkbox"/> INITIAL TX Health Steps Medical Checkup | Procedures: _____ |
| <input type="checkbox"/> Annual/Age-appropriate TX Health Steps Medical Checkup | Procedures: _____ |
| <input type="checkbox"/> OTHER recommended Medical Checkup | Procedures: _____ |
| <input type="checkbox"/> ER Visit | Procedures: _____ |
| <input type="checkbox"/> Acute Care / Follow-up visit | Procedures: _____ |

Physical Exam Results: (please complete below or attach a copy of your own medical record or the TX Health Steps form)

Age: _____ Height: _____ %: _____
(circle) Years / Months / Weeks Weight: _____ %: _____

Temperature: _____ Pulse: _____ Respirations: _____ Blood Pressure: _____

Child refused the examination Comments: _____

VISION

Vision Checkup Procedures: _____

HEARING

Hearing Checkup Procedures: _____

DENTAL

- | | |
|---|-------------------|
| <input type="checkbox"/> INITIAL TX Health Steps Dental Checkup | Procedures: _____ |
| <input type="checkbox"/> Six month TX Health Steps Dental Checkup | Procedures: _____ |
| <input type="checkbox"/> Other recommended Dental Checkup | Procedures: _____ |

PSYCHIATRIC APPOINTMENT

Evaluation Medication Review Lab: _____

REFERRALS

- | | |
|---|---|
| <input type="checkbox"/> Early Childhood Intervention (ECI) | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Alcohol & Drug Screening |
| <input type="checkbox"/> Specialist As specified: _____ | |
| <input type="checkbox"/> Diagnostic Assessment/s, if necessary: _____ | |
| <input type="checkbox"/> Other, as specified: _____ | |

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MEDICATIONS AND MEDICATION CHANGES

MEDICATION	DOSAGE	PRESCRIBED FOR	INSTRUCTIONS, IF ANY	DISCONTINUED	NEW
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

PROCEDURES: _____

DIAGNOSIS / TEST RESULTS: _____

RECOMMENDED FOLLOW-UP, APPOINTMENTS SCHEDULED: _____

IMMUNIZATIONS

(If appropriate, complete immunization record & give updated record to Care Giver)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Health Care Provider		Address	
Printed Name of Health Care Provider		City, State, Zip Code	
Signature of Caregiver <i>(if completed by caregiver)</i>		Phone #	