

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.

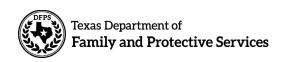
If the health care provider is unable to complete Section II, the person taking the child or youth to the appointment completes Section II, signs his or her name, and checks the box labeled: *health care provider unable to complete*. The health care provider may attach medical records or other information 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 Name:	Date of Birth	1:	Person Identification (PID) Number:		on	Appointment Date:		
CAREGIVER INFORMATION								
CAI	REGIVER INFO	URMA	IION					
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:			
CASEWORKER INFORMATION								
Caseworker's Name:		Phone	Number:		Fax:			



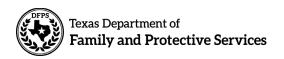
REASON FOR VISIT
3-Day Medical Exam. (Required within three business days of removal with some exceptions, such as DFPS removal while child is in a hospital setting).
Child or Youth with Primary Medical Needs. (Required within seven days before or three days after placement date).
Initial Child and Adolescent 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).
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).
Initial Texas Health Steps Medical Checkup. (Required within 30 days of entering DFPS conservatorship).
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) Caregiver Comments:								
Medication	Dosage		Prescribed for	Instructions				
Caregiver Comments:								
SIGNATURE OF PERSON COMPLETING SECTION 1								
DFPS Staff or Caregiver Signat	ure:	Date	e Signed:					
X								
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:	Week	s:	Temperature:		Pulse:		Respirations:		Blood Pressure:	
Height:		W	/eight:	··	Head Circum %:			mference: BMI		: %:	
VISION S				,		70.			701		
Not do		ild or vo	uth unah	ole to co	mply with	screening		Refused			
			500							4000	
	R										
	L										
DIAGNOS	SES:										
Well C	Child or No De	ental Pro	blems	Othe	er (list):						
NEW OR	CHANGED M	IEDICAT	TIONS (ONLY:							
☐ No Me	dication Cha	nges									
Name	e Dos	sage	Presc	ribed fo	r Instru	uctions	tions 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	None Necessary						
Return Visit: When and Why							
Provider Comments:							
PROVIDER INFORMATION							
Provider Signature:		Clinic Name:	Phone:				
X							
Printed Name:	Address:		Fax:				
Date Signed:	City, State, Zip						
If Coation II is not completed by		al municidae Aba annaniuseu aine b	-la				
If Section II is not completed by	a medical or denta		eiow.				
Caregiver Signature:		Date Signed:					
X							
The health care provider was unable to complete this form.							
PRIVACY STATEMENT							
DFPS values your privacy. For more information, read our <u>Privacy and Security Policy</u> .							
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