MEDICAL/DENTAL/VISION/HEARING EXAMINATION FORM

For STAR Health related questions, please contact the STAR Health Member Services Hotline at 866-912-6283

I. GENERAL INFORMATION (This page to be completed by Caseworker/Caregiver. Please print legibly)

CHILD:

CHILD NAME:	DOB:	PID#	EXAMINATION DATE:

CAREGIVER:

CAREGIVER NAME:	PHONE:	AGENCY:
ADDRESS:	CITY/STATE/ZIP:	

CPS CASEWORKER:

CASEWORKER NAME:	PHONE:	FAX:

REASON FOR VISIT:

☐ Child with Primary Medical Needs	(Needs a medical examination within 7 days before or 3 days after the date of placement).
☐ Initial TxHSteps Medical Checkup	(Needs within 30 days of entering DFPS conservatorship).
☐ Regular TxHSteps Medical Checkup	(Needs at following interval: discharge to 5 days, 2 weeks, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 36m, then yearly).
☐ Initial TxHSteps Dental Checkup	(Needs checkup within 60 days of entering DFPS conservatorship if 6m or older. Within 30 days after turning 6m old).
☐ Regular TxHSteps Dental Checkup	(Needs every 6 months or as recommended by dentist).
☐ Vision Check	
☐ Hearing Check	

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

_____

_____

_____

☐ Child needs to see a specialist. (Please specify specialist type and reason for referral):

_____

_____

MEDICATIONS:

ALLERGIES: ☐ None ☐ Yes (list):

CHILD IS CURRENTLY ON THESE MEDICATIONS:

Name	Dosage	Prescribed for	Instructions

SIGNATURE OF PERSON FILLING THIS SIDE OUT (DFPS STAFF OR CAREGIVER)

DFPS STAFF OR CAREGIVER SIGNATURE	DATE:

II. HEALTH CARE EXAMINATION (This page to be completed by Health Care Provider OR Caregiver [if Health Care Provider is unable to complete.])

CHILD'S NAME:	DOB:	EXAMINATION DATE:

VISIT TYPE:

MEDICAL:	TxHSTEPS ☐ Initial ☐ Regular	☐ Acute/Follow-up Visit	☐ Other Recommended Medical Checkup	☐ ER Visit
DENTAL:	TxHSTEPS ☐ Initial ☐ Bi-Annual		☐ Other Recommended Dental Checkup	
SPECIALTY:	☐ Visit – Please list Specialty:			

VISIT RESULTS: ☐ Child Refused Examination

VITALS:

AGE: **Years:** _____ **Months:** _____ **Weeks:** _____

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

Height: _____ **%:** _____ **Weight:** _____ **%:** _____ **Head Circ:** _____ **%:** _____ **BMI:** _____ **%:** _____

VISION & HEARING:

Vision Screen: R 20/_____ L 20/_____ ☐ no glasses ☐ glasses ☐ didn't bring glasses ☐ not done ☐ too many prompts ☐ refused

Hearing Screen:

	500	1000	2000	4000
R				
L				

☐ not done ☐ too many prompts ☐ refused

PROCEDURES OR TESTS:

☐ None ☐ TB Screen ☐ Lead Screen ☐ Developmental Screen ☐ Autism Screen ☐ Hemoglobin ☐ Blood Lead Test ☐ PPD ☐ Other (list):

DIAGNOSES:

☐ Well Child/Dental ☐ Other (list):

****NEW** OR **CHANGED** MEDICATIONS *ONLY***

☐ No Medication Changes

Name	Dosage	Prescribed for	Instructions	D/C'd	New	Changed
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

VACCINES GIVEN:

☐ None Given ☐ DTaP ☐ DT ☐ Tdap ☐ HIB ☐ PCV ☐ Td ☐ MMR ☐ Varicella ☐ Hep A ☐ Hep B ☐ IPV ☐ Rotavirus ☐ HPV ☐ MCV ☐ Influenza ☐ Pneumovax ☐ Other (list):

REFERRED TO:

☐ None Necessary ☐ ECI (Early Childhood Intervention) Therapy: ☐ Speech ☐ Occupational ☐ Physical ☐ Specialist (list) ☐ Other (list:)

FOLLOW-UP:

☐ None Necessary ☐ Next WCC ☐ Return Visit: When: Why:

PROVIDER INFORMATION: Are you a TxHSteps Provider? ☐Y ☐N

PROVIDER SIGNATURE	CLINIC NAME	PHONE
PRINTED NAME	ADDRESS	FAX
DATE SIGNED	CITY, STATE ZIP	

CAREGIVER: (If Section II above is NOT filled out by medical/dental provider then the Caregiver should sign in the space below.)

CAREGIVER SIGNATURE	DATE