Santa Clara County
Social Services Agency
Department of Family and Children's Services

HEALTH CONTACT FORM

Caretaker: Please have a form completed for <u>EVERY</u> Medical, Clinic, or Dental visit, including CHDP exams, and return the copy to the CHDP Unit at the address below.

Mail, email or fax to:
CHDP Unit
Santa Clara County
Social Services Agency
373 West Julian Street
San Jose, CA 95110-2335
PHNEmail@ssa.sccgov.org
CHDP: (Tel.) 408-501-6669
(Fax) 408-792-1411

SECTION A (To be completed by Foster Parent/Caregiver

Child's Name: _____ DOB: _____
Foster/Relative Caregiver: _____
Foster/Relative Caregiver Telephone Number: _____
Social Worker: _____ Phone: _____
Primary Medical Provider: _____

SECTION B (To be completed by Health Care Provider) DATE OF EXAMINATION: _____

MEDICAL
- ☐ Well Child/Physical
- ☐ Sick visit/Urgent
- ☐ Medication
- ☐ Follow-up
- ☐ Other: _____

DENTAL
- ☐ Exam/ X-rays
- ☐ Fluoride
- ☐ Cleaning
- ☐ Sealant/Fillings _____
- ☐ Orthodontia
- ☐ Other: _____

SPECIALTY
- ☐ Type: _____
- ☐ Initial visit
- ☐ Follow-up
- ☐ Other: _____

DATE OF EXAMINATION: _____
Height: _____
Weight _____ BMI: _____
Head circumference: _____
Vision: _____ ☐ Normal ☐ Referred
Hearing: _____ ☐ Normal ☐ Referred

DIAGNOSIS:
- ☐ Well-child
- ☐ No problems identified
- ☐ Allergies:
- ☐ ICD-9/ Diagnosis: _____
- ☐ Labs: _____

IMMUNIZATIONS: (Mark those <u>given today</u> or attach record)

☐ IPV	☐ HEPB	☐ FLU
☐ DtaP / Tdap	☐ PNU	☐ HPV
☐ HIB	☐ VZV	☐ MENNIN
☐ MMR	☐ HAV	☐ ROTA

- ☐ Other: _____
- ☐ Chickenpox disease history date: _____

TB Mantoux (PPD): Date Given: _____
Date Read: _____
Results ☐ Neg ☐ Pos _____ mm.
Chest X-ray: Date: _____ ☐ Normal ☐ Abnormal
- ☐ Rx Start Date: _____
- ☐ Meds: Rx Duration: _____

MEDICATION / TREATMENTS / COMMENTS:

REFERRALS:
- ☐ Medical specialty
- ☐ Developmental assessment
- ☐ Speech/hearing
- ☐ Early start
- ☐ Mental health
- ☐ Other:

SECTION C (To be completed by the health care provider)

Health Care Provider Name and Address (stamp or print):
Telephone Number: _____ **Date:** _____

Three (3) copies: Caretaker, CHDP, Health Care Provider