

## 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.

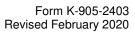
If the health care provider is unable to complete Section II, the person taking the child or youth to the appointment completes Section II, signs his or her name, and checks the box labeled: *health care provider unable to complete*. The health care provider may attach medical records or other information 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								
Date of Bi	th:	Person Identification (PID) Number:		on A	Appointment Date:			
				I				
REGIVER IN	IFORMA	TION						
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.								
Phone:		Agency:						
City:			State:		Zip:			
1					,			
CASEWORKER INFORMATION								
Caseworker's Name:				Fax:				
	Date of Bir  REGIVER IN  -relative, or  Phone:  City:	Date of Birth:  REGIVER INFORMA -relative, or represer  Phone:  City:	Date of Birth:  Person Id (PID) Nur  REGIVER INFORMATION  -relative, or representative of a  Phone:  Agency:  City:	Date of Birth:  Person Identification (PID) Number:  REGIVER INFORMATION  -relative, or representative of a residential phone:  Agency:  City:  State:	Date of Birth:  Person Identification (PID) Number:  REGIVER INFORMATION  -relative, or representative of a residential operation  Phone:  Agency:  City:  State:			



REASON FOR VISIT
<b>3-Day Medical Exam.</b> (Required within three business days of removal with some exceptions, such as DFPS removal while child is in a hospital setting). Immunizations are not allowed at this exam unless an emergency situation requires tetanus vaccination, or if the provider gets direct consent from the biological parent(s).
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 newborn hospitalization, 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.
Usion Check. ☐ Hearing Check. ☐ ER Visit. – Reason:
ER Visit Reason:
ER Visit Reason:

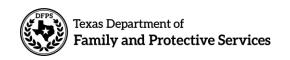




Illness, injury or accident or other follow-up visit. (Describe the injury, accident or illness, including the date and time of the incident.)

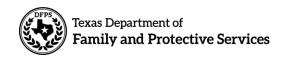


MEDICATIONS									
☐ No ☐ Yes (List) Caregiver Comments:									
Medication	Dosage	Prescribed for	Instructions						
Caragiyar Comments									
Caregiver Comments:									



SIGNATURE OF PERSON COMPLETING SECTION					
DFPS Staff or Caregiver Signature:	Date Signed:				
X					

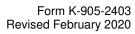
SECTION II. HEALTH CARE APPOINTMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)							
Child or Youth's Name:	Date of Birth:	Appointment Date:					



VISIT RESULTS										
Child o	r youth refus	ed a <sub>l</sub>	ppointment	-						
VITALS:										
Years:	Months:	We	eks:	Temp	erature:	Pulse:	Respirations:		Blood Pressure:	
Height:			Weight:			Head Circumference:			BMI:	
%:			%	:		%:			%:	
VISION S	CREEN:	F	R: 20/		<b>L:</b> 20	0/				
		No	glasses		Glasses 🔲	Did not bring g	lasses			
Cubica	tively normal	_	Not done	. П	Child or you	uth unable to co	amply with core	onina	Refused	
	lete eye exan					utii uiiabie to ct	onipiy with stre	ening	Refused	
HEARING										
			500Hz		10	000Hz	2000Hz		4000Hz	
F	2									
	_									
Subjec	tively normal	Г	Not done	≘П с	hild or youtl	h unable to com	nply with screer	ning	Refused	
_	te audiology							_		
PROCEDU	RES OR TES	TS:	None		B screen	Lead screen	Develop	ment	al screen	
Autisr	n screen	Hem	oglobin	PPD	Blood le	ad test Oth	er (list):			
DIAGNOS	EC.									
DIAGNOS	E5:									



☐ Well Child ☐ Routine Dental Visit ☐ Other (list):							
Name	Dosage	Prescribed for	Instructions	Discontinued	New	Changed	
						П	
					П		
No Medication Changes							
<b>VACCINES:</b> Children and youth are prohibited from receiving vaccinations at the 3-Day Medical Exam unless an emergency situation requires tetanus vaccination, or if the provider gets direct consent from the biological parent(s).							
None Administered							





☐ DTap ☐ Tdap ☐ HIB ☐ PCV ☐ Td ☐ MMR ☐ Varicella ☐ Hep A ☐ Hep B ☐ IPV ☐ HPV
MenA MenB Rotavirus Influenza PCV13 PPSV23
Other (list):
REFFERED TO:
None Necessary
ECI (Early Childhood Intervention) Speech Therapy Occupational Therapy Physical Therapy
Specialist (Type): Other (Type):
FOLLOW-UP:
None Necessary
Return Visit: When and Why
Provider Comments:



PROVIDER INFORMATION							
Provider Signature:	Clinic Name:	Pho	Phone:				
X							
Printed Name:	rinted Name: Address:			Fax:			
Date Signed:	City, State, Zip						
If Section II is not completed by a medical or dental provider, the caregiver sign below.							
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>.