Utah DHS-DCFS Form 984

HEALTH VISIT REPORT

Rev August 09

Child's Name ______________________ **D.O.B.**__________ **Current Age**_____

Date of Visit: ________________ **Medicaid ID Number**______________

Attending visit: Parent Foster Parent Tracker Other: **Caseworker Name**______________

Select Visit Type: WCC Sick Visit Dental/Ortho Mental Health/Therapy Med Mgmt. Other:__________

PLEASE PRINT

Ht.______ **Wt.**______ **BMI**______ **OFC**____ ____%

T______ **B/P**_____/_____ **P**______ **RR**______

Vision Screen: **OD** 20/ **OS** 20/ **OU** 20/

Lab tests: Hgb/Hct UA HCG STI PPD Other:

Results:

Pertinent Past History:

Allergies: NKMA PCN Sulfa Other:__________

Review of Systems/ Physical Exam

CIRCLE: **N**-Normal Deferred **A**-Abnormal **(described if abnormal)**

Growth/Dev: N D A__________

Head: N D A__________

Eyes: N D A__________

Ears: N D A__________

Nose: N D A__________

Throat: N D A__________

Pulmonary: N D A__________

Cardiac: N D A__________

G.I.: N D A__________

G.U.: N D A__________

Pelvic: N D A__________

Musculo/Skeletal: N D A__________

Skin: N D A__________

Immunizations Given: Hep B Hep A MMR MMRV Varicella Tdap DTap Td HPV Menactra PCV RGE Prevnar IPV HIB Flu

Other: __________

Diagnosis:

Plan: (Include Medications)

Treatments:

Follow-up/Referrals:

(Next available appointment will be scheduled unless noted it is urgent.)

Next Appointment: **PRN** **Routine**

Needs follow-up__________

Date scheduled

Did you have enough information for the care of this child YES NO

Medical Provider Name & Facility______________________

PLEASE PRINT

NPI #______________ **Office Phone Number**______________

Health Provider Signature______________ Date__________

White Copy - DCFS FHC Program Yellow - Child's Home Binder Pink-Medical Provider

AUTOMATIC COVER SHEET

DATE: JUN-01-2012 FRI 11:41 AM

TO:

FAX #: 18772755981

FROM: STARLIGHT

FAX #: 8017472086

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