Health Care Program for Children in Foster Care (HCPCFC)
Foster Care Medical (Specialty) Contact Form

Submit to the Santa Cruz Family Child Services PHN within 5 business days of the examination at FAX: (831) 454-4501 ATT: MAYRA

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system.

Patient Name (Last) (First) (Initial) | **Language** | **Date of Service** Month Day Year

Birthdate Month Day Year | **Age(yr/m)** | **Sex** | **Gender** | **Patient's County of Residence** | **Telephone #** (Home or Cell) | **Alternate Phone #** (Work or Other)

Responsible Person (Name) (Street) (Apt/Space) (City) (Zip)

Ethnic Code ☐
1-White
2-Hispanic/Latino
3-Black/African American
4-American Indian/Alaska Native
5-Asian
6-Native Hawaiian/Other Pacific Islander
7-Other

Patient Eligibility: County Code | Aid Code | Identification Number | **Next CHDP Exam** Month Day Year

A. Medical Assessment and Referral Section

Type of Visit:

MEDICAL ☐ Well Child Exam ☐ Immunization Visit ☐ Sick Visit/Urgent Care ☐ Reproductive Health ☐ Follow Up

SPECIALTY ☐ Initial Consultation ☐ Follow Up

Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health) _____

Height To nearest 0.1 cm	Height Percentile	**Weight** To nearest 0.1 kg	Weight Percentile	**BMI**	BMI Percentile	**Head Circumference**	Head Circ. Percentile

Blood Pressure	**Hemoglobin**	**Hematocrit**	**Vision Results** OD OS OU	**Hearing Results** R L

Labs Ordered ☐ CBC ☐ Lead ☐ Other:_____ | **Date Labs Ordered** | **Lab Results**

Any known **allergies** to medication/food/environment? ☐ Y ☐ N Please list:_____

ASSESSMENT/DIAGNOSIS:

Depression Screening: ☐ Y ☐ N **Substance Abuse Screening:** ☐ Y ☐ N **Tool Used (if any)?** _____

MEDICATIONS/TREATMENTS:
(DOSAGE/FREQUENCY)

If prescribed psychotropic medication was a
JV220 (A) completed? ☐ Y ☐ N
Was EKG completed? ☐ Y ☐ N
Were Labs completed? ☐ Y ☐ N

DEVELOPMENTAL SCREENING/ASSESSMENT: **Completed today?** ☐ Y ☐ N

Developmental tool used, if any: (Please attach a copy) ☐ ASQ-3 ☐ ASQ-SE ☐ Other (Specify):_____

Age appropriate development? ☐ Y ☐ N **if NO, Indicate:** ☐ Gross ☐ Fine ☐ Speech/Language ☐ Social/Emotional ☐ Cognitive

Physical Growth ☐ WNL ☐ Delayed

_____

REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)

IMMUNIZATIONS
☐ **Copy of IZ Records Attached?**
Please check (☑) which immunizations have been given TODAY:

IPV	1☐	2☐	3☐	4☐	
DTaP	1☐	2☐	3☐	4☐	5☐
Td	☐				
Tdap/Booster	☐				
Hib	1☐	2☐	3☐	4☐	
MMR	1☐	2☐			
Hep B	1☐	2☐	3☐		
Hep A	1☐	2☐			
VZV	1☐	2☐			
PCV	1☐	2☐	3☐	4☐	5☐
PCV13	☐				
MenACWY	☐				
HPV	1☐	2☐	3☐		
Influenza	1☐	2☐			
Rotavirus	1☐	2☐	3☐		

Other:_____
☐ **Up to date** ☐ **Not up to date**

☐ **PPD** ☐ **TB Risk Assessment**
Date Given:_____
Date Read:_____
Results: ☐ **Negative** ☐ **Positive**
☐ **Return for PPD Read**
☐ **Lab ordered for QFT/IGRA**

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis
Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis
Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain
Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

☐ **Dental home referral** **Referred To and Contact Number:** _____

C. Provider Information

Service Location: Office Name, Address, Telephone/Fax Number

NPI Number

Provider Name (Print Name)

Provider Signature | **Date**

Follow up appointments needed? ☐ Y ☐ N **Date/Time**_____

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