**HEALTH CARE ENCOUNTER**

# Health Care Provider: Please complete for any health care visit

**Please take this form to your Health Care Provider.**

**Favor de llevar ésta forma a su proveedor de Cuidado Médico.**

## Date of Visit: / / Name: DOB:

Foster Care  Probation

|  |  |  |  |
| --- | --- | --- | --- |
| **Growth:** | **HT:** | **WT:** | **HC:** |
| **Diagnosis:** |  | | |
| **Treatment/Medication:** |  | | |
| **Immunizations Given:** |  | | |
| **Tests:** |  | | |  |
| **Additional Comments:** |  | | |

### CHECK ONE: Routine CHDP Exam Mental Health Specialist Visit

### Sick Visit Follow-Up

### Routine Dental Exam Dental Follow-Up

(Check any below that apply) (Check any below that apply)

Cleaning  Further work/restoration

Fluoride Application

Referral made to:

Currently receiving services from:  CA Children’s Services  Regional Center  Other

**Signature of Provider:**   **Telephone:**

**Name of Provider:**   **Fax No:**

**Address:**

For Health/Education Passport Update: PLEASE RETURN IN THE POST PAID ENVELOPE TO:

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

DEPARTMENT OF SOCIAL SERVICES P.O. Box 8119, San Luis Obispo, CA 93403-8119

**or FAX to: (805) 781-1701 - ATTN: Mallory Vanoli, PHN**

QUESTIONS: Please call: (805) 781-1715