**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