MEDICAL/DENTAL/VISION EXAMINATION FORM

GENERAL INFORMATION (This section to be completed by Caseworker/Caregiver. Please print legibly.)

CHILD's NAME: ____________ DOB: ________ PID #: ____________ DATE: PLACED: ________

CAREGIVER: ____________ PHONE: ____________ AGENCY: ____________

ADDRESS: ____________ CITY: ____________ ZIP: ________

CPS CW: ____________ PHONE: ____________ FAX: ____________

Select the reason for visit:

- ☐ Child with Primary Medical Needs (PMN) needs a medical examination within 7 days before or 3 days of placement.
- ☐ Child needs an initial Texas Health Steps Medical Checkup by a Texas Health Steps provider within 30 days of entering DFPS conservatorship
- ☐ Child under age 36 months needs an additional age-appropriate Texas Health Steps Medical Checkup per Periodicity Schedule (3 to 5 days after birth, 2 weeks after birth, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months)
- ☐ Child age 36 months or older needs an additional age-appropriate Texas Health Steps Medical Checkup annually
- ☐ Child age 6 months or older needs an initial Texas Health Steps Dental Checkup by a Texas Health Steps provider within 60 days of entering DFPS conservatorship
- ☐ Child under age 6 months upon entry into DFPS conservatorship needs an initial Texas Health Steps Dental Checkup by a Texas Health Steps provider within 30 days of becoming age 6 months
- ☐ Child needs an additional Texas Health Steps Dental Checkup every 6 months, or as recommended by the Texas Health Steps provider
- ☐ Child needs a Vision Checkup
- ☐ Child needs a Hearing Checkup
- ☐ Child needs to see a health care provider for an illness, injury or accident or other follow up visit Please describe injury, accident or illness, including the date and time of the incident:

____

____

- ☐ Child needs to see a specialist. Please specify:

____

____

Signature of DFPS staff or Caregiver: ____________________ Date ____________

II. HEALTH CARE EXAMINATION (This section to be completed by Health Care Provider.)

e you a Texas Health Steps provider? ☐ Yes ☐ No
Was child tested for lead poisoning? ☐ Yes ☐ No
Did child receive TB screening? ☐ Yes ☐ No

Date of Examination: ______________ Name of Health Care Provider: ______________________

Check all that apply:

Medical:

☐ Initial Texas Health Steps Medical Checkup
☐ Annual/Age-appropriate Texas Health Steps Medical Checkup
☐ Other recommended Medical Checkup
☐ Acute Care/Follow-up visit.
☐ ER visit

Vision:

☐ Vision Checkup

Hearing:

☐ Hearing Checkup

Dental:

☐ Initial Texas Health Steps Dental Checkup
☐ Six month Texas Health Steps Dental Checkup
☐ Other recommended Dental Checkup

Specialty:

☐ Specialist visit as specified______________________________________

Referred to:

☐ Early Childhood Intervention (ECI)
☐ Speech Therapy
☐ Physical Therapy
☐ Occupational Therapy
☐ Specialist, as specified____________________
☐ Other, as specified____________________

Please complete the following information or attach a copy of your own medical record or the Texas Health Steps form:

Physical Exam Results:

Age:	________	Temperature	________	Height:	________	%:	________
Years:	________	Pulse	________				
Months:	________	Respirations	________	Weight:	________	%:	________
Weeks:	________	Blood Pressure	________				

☐ Child refused the examination

Medications and changes:

Name	Dosage	Prescribed for	Instructions, if any	Discontinued	New
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Procedures

Diagnosis/Test Results

Recommended Follow Up, Appointments Scheduled

Immunizations Given (If appropriate, complete immunization Record)

Signature of Health Care Provider	Date	Phone
Address	City/State	Zip
Signature of Caregiver (if completed by caregiver)	Date	