******State of Connecticut Department of Children & Families**

DCF-2147 Medical Questionnaire/Request for Information

Revised January 2013

**Medical Questionnaire/Request for Information**

|  |  |  |
| --- | --- | --- |
| To: | HEALTH CARE PROVIDER      | DATE      |
| ADDRESS      | FAX      |

|  |  |  |
| --- | --- | --- |
| From: | DCF INVESTIGATOR      | TELEPHONE      |
| AREA OFFICE      | FAX      |

The Department of Children and Families has an open investigation concerning the child listed below. In accordance with our investigation policies, we are requesting information that would become part of the confidential file. Enclosed is a signed authorization to release information for your records. We ask that you take a moment to complete this form and return it to us **within two weeks**. Thank you for your anticipated assistance in this matter.

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| --- |
| Family or Custodial Parent's Name:       |
| Child/Youth:       | DOB:       |
| Date of Last Physical:       | HT:       WT:       BMI:       |
| How long has the child been a patient in your practice?       years |
| Has child been seen elsewhere for medical care? If so, where? | NAME OF PROVIDER:      |
| Is the patient up to date with immunizations and well child visits? | [ ]  YES[ ]  NO | IF NO, WHAT IS NEEDED?      |
|       |
| Has child had lead level checked? | [ ]  YES[ ]  NO | IF YES, DATE:      | LEVEL:      |
| Are there any identified medical or dental problems? | [ ]  YES[ ]  NO | IF YES, PLEASE EXPLAIN:      |
|       |
| Are there any developmental, behavioral, or mental health concerns? | [ ]  YES[ ]  NO | IF YES, PLEASE EXPLAIN CONCERN AND ANY SPECIALIST REFERRALS MADE:      |
|       |
|       |
| **If the patient is less than three (3) years of age**would this patient benefit from a referral of **Birth to Three Services**? | [ ]  YES[ ]  NO | If YES, was a referral made to **Birth to Three**? [ ]  YES [ ]  NO [ ]  Check here if patient already involved with **Birth to Three** |

|  |  |  |
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| Is the child presently on any medication? | [ ]  YES[ ]  NO | IF YES, PLEASE LIST MEDICATION AND WHAT IT IS PRESCRIBED FOR:      |
|       |
|       |
| List any specialist referrals made and dates: | NAME OF SPECIALIST:      | DATE OF REFERRAL:      |
|       |       |
|       |       |
| Any missed appointments/ pattern of missed appointments or other concerns you would like to discuss with the DCF investigator? |       |
|       |
|       |

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| --- | --- | --- | --- |
| Health CareProvider's Signature: |  | Date: |       |

|  |  |
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| **[ ]  Need to speak with Social Worker** | BEST DAYS AND TIMES TO CONTACT: |
| Days: |       |
| Times: |       |
| Telephone: |       |
|  |

|  |  |
| --- | --- |
| Please attach a copy of: | [ ]  Immunization records |
|  | [ ]  Last physical exam |
|  |  |
| Fax to: |       |
| Fax # |       |

**PLEASE RETURN WITHIN TWO WEEKS**