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| **COMPLETE FOR ANY HEALTH CARE VISIT** | | | | | | | | | | | | | | | | | | | | |
| Date of Visit: | | | Type of Visit (check one):  Medical  Dental  Mental Health  Well Child Exam  Sick Visit  Follow-up Visit  Other: (Please specify): | | | | | | | | | | | | | | | | | |
| Social Worker LAST NAME: | | | | | Social Worker FIRST Name: | | | | | | SW E-mail: | | | | | | | | SW Phone: | |
| DCF Office: | | | | | | | | | | | | | | | | | | | SW Fax: | |
| Child LAST Name: | | | | | | Child FIRST Name: | | | | | | DOB: | | | | Gender: | | | | |
| Child’s Age: | | Primary Language: | | | | | | | Case ID #: | | | | | | | | Person ID #: | | | |
| **PROVIDER** | | | | | | | | | | | | | | | | | | | | |
| Growth: | Height:       ‘ | | | “ | | | Weight:        Lbs. | | | | | | BMI: | | | | | HC: | | |
| Diagnosis: | | | | | | | | | | | | | | | | | | | | |
| Lab work / Tests ordered?  Yes  No. If yes, please explain: | | | | | | | | | | | | | | | | | | | | |
| Immunizations Given?  Yes  No. If yes, please list: | | | | | | | | | | | | | | | | | | | **Attach a copy of completed immunization record** | |
| Findings / Comments: | | | | | | | | | | | | | | | | | | | | |
| Recommendations / Treatment / Medication: | | | | | | | | | | | | | | | | | | | | |
| Referral to Specialist?  Yes  No. If yes, please indicate the name of the specialist and the reason for referral: | | | | | | | | | | | | | | | | | | | | |
| Follow-up needed?  Yes  No. If yes, please indicate Date of Next Appointment: | | | | | | | | | | | | | | | | | | | | |
| Provider Name | | | | | | | | Provider E-mail: | | | | | | | Provider Phone: | | | | Provider Fax: | |
| Provider Address (No. and Street) | | | | | | | | Apt/Suite. #: | | City: | | | | | | State: | | | | Zip: |
| **I Need to Speak with a Social Worker** | | | | | | | | Best method to contact: | | | | | | E-mail: | | | | | Phone: | |