HEALTH SUMMARY
DCF-741 HS
7/2026 (Rev.)

Case Name				Case ID #	
Child/Youth				PID#	
Child's Age		Child's D.O.B.		Medically Complex Level	Select a Level
DCF SW:			Phone		
DCF SWS:			Phone		

ACTIVE DIAGNOSIS
INACTIVE DIAGNOSIS

ALLERGIES

MEDICAL PROVIDERS & MEDICAL APPOINTMENTS:			
Health Care Provider Name/Specialty	**Location/ Telephone #**	**Completed Appointment**	**Scheduled Appointment**

MEDICATIONS			
MEDICATION NAME	**DOSE/ FREQUENCY**	**PRESCRIBER**	**PHARMACY**

HEIGHT	WEIGHT	BMI
NUTRITIONAL PLAN		

CURRENT DME NEEDS
UNMET DME NEEDS

SUPPLY COMPANY CONTACT INFORMATION:	
Name of Supply Company	**Contact Information**

ACTIVITIES OF DAILY LIVING/CARE NEEDS: Does child require assistance with ADL's (note if age is appropriate or explain)	
Bathing	
Toileting	
Getting Dressed	
Feeding	
Ambulation	
Positioning/Repositioning	
Communication method	
Hearing /Visual impairment	
Other	