TX DEPT OF FAMILY SERVICES AND PROTECTIVE SERVICES FORM 2403

Revised September 2013

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| **MEDICAL/DENTAL/VISION/HEARING EXAMINATION FORM**  **For STAR Health related questions, please contact the STAR Health Member Services Hotline at 866-912-6283** |
| **l. GENERAL INFORMATION (This page to be completed by Caseworker/Caregiver. Please print legibly)** |
| **CHILD:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Child Name: |  | DOB: |  | PID# |  | Examination Date: | |
| **CAREGIVER:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Caregiver Name: |  | Phone: |  | | Agency: |  | | Address: |  | City/State/Zip: | |  | | |   **CPS CASEWORKER:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Caseworker Name: |  | Phone: |  | Fax: |  | |
| **REASON FOR VISIT:**   |  |  | | --- | --- | | Child with Primary Medical Needs | (Needs a medical examination within 7 days before or 3 days after the date of placement). | | Initial TxHSteps Medical Checkup | (Needs within 30 days of entering DFPS conservatorship). | | Regular TxHSteps Medical Checkup | (Needs at following interval: discharge to 5 days, 2 weeks, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 36m, then yearly). | | Initial TxHSteps Dental Checkup | (Needs checkup within 60 days of entering DFPS conservatorship if 6m or older. Within 30 days after turning 6m old). | | Regular TxHSteps Dental Checkup | (Needs every 6 months or as recommended by dentist). | | Vision Check | | | Hearing Check | | | 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 specialist type and reason for referral):   |  | | --- | |  | |  | | | |
| **MEDICATIONS:**   |  |  | | --- | --- | | **Allergies:** | None  Yes (list): |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **CHILD IS CURRENTLY ON THESE**  **MEDICATIONS:** | Name | Dosage | Prescribed for | Instructions | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **SIGNATURE OF PERSON FILLING THIS SIDE OUT (DFPS STAFF OR CAREGIVER)**   |  |  |  | | --- | --- | --- | | DFPS Staff or Caregiver Signature | Date: |  | |

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| **ll. HEALTH CARE EXAMINATION (This page to be completed by Health Care Provider OR Caregiver [if Health Care Provider is unable to complete.])**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Child’s Name: |  | DOB: |  | Examination Date: | |
| **VISIT TYPE:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **MEDICAL:** | TxHSTEPS  Initial  Regular | Acute/Follow-up Visit | Other Recommended Medical Checkup | ER Visit |  |  |  |  | | --- | --- | --- | | **DENTAL:** | TxHSTEPS  Initial  Bi-Annual | Other Recommended Dental Checkup |  |  |  | | --- | --- | | **SPECIALTY:** | Visit – Please list Specialty: | |
| **VISIT RESULTS:**  Child Refused Examination   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **VITALS:** | AGE: | |  |  | | --- | --- | |  |  | | **Years:** |  | | **Months:** |  | | **Weeks:** |  | | |  |  | | --- | --- | | **Temperature:** |  | | **Pulse:** |  | | **Respirations:** |  | | **Blood Pressure:** |  | | |  |  |  |  | | --- | --- | --- | --- | | **Height:** |  | **%:** |  | | **Weight:** |  | **%:** |  | | **Head Circ:** |  | **%:** |  | | **BMI:** |  | **%:** |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **VISION & HEARING:** | Vision  Screen | **R** 20/   \_\_\_ **L** 20/   \_\_  no glasses  glasses  didn’t bring glasses | not done  too many prompts   refused | Hearing  Screen | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | **500** | **1000** | **2000** | **4000** | | **R** |  |  |  |  | | **L** |  |  |  |  | | not done  too many prompts   refused |  |  |  |  |  | | --- | --- | --- | --- | | **PROCEDURES**  **OR TESTS:** | None | TB Screen  Lead Screen  Developmental Screen  Autism Screen | Hemoglobin  Blood Lead Test  PPD  Other (list): |  |  |  | | --- | --- | | **DIAGNOSES:** | Well Child/Dental  Other (list): |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **\*\*NEW\*\***  **OR**  **\*\*CHANGED\*\***  **MEDICATIONS**  ***ONLY***  No Medication Changes | Name | Dosage | Prescribed for | Instructions | D/C’d | New | Changed | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **VACCINES**  **GIVEN:** | None  Given | DTaP  DT  Tdap | HIB  PCV  Td | MMR  Varicella  Hep A | Hep B  IPV  Rotavirus | HPV  MCV  Influenza | Pneumovax  Other (list): |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **REFERRED TO:** | None Necessary  ECI (Early Childhood Intervention) | Therapy: | Speech  Occupational  Physical | Specialist (list) | | Other (list:) |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **FOLLOW-UP:** | None  Necessary | Next WCC | Return Visit: | When:  Why: | |
| **PROVIDER INFORMATION:** Are you a TxHSteps Provider?Y  N   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Provider Signature | | Clinic Name |  | Phone |  | | Printed Name |  | Address |  | Fax |  | | Date Signed |  | City, State Zip |  | | | |
| **CAREGIVER: (If Section II above is NOT filled out by medical/dental provider then the Caregiver should sign in the space below.)**   |  |  | | --- | --- | | Caregiver Signature | Date | |