

## MEDICAL, DENTAL, VISION, HEARING, OR BEHAVIORAL HEALTH APPOINTMENT

**Purpose:** Use this form to document medical, dental, vision, hearing and behavioral health (Child and Adolescent Needs and Strengths assessment (CANS)) appointments. Completion of this form meets requirements in:

- Residential Child Care Licensing Minimum Standards
- Residential Child Care Contracts
- Child Protective Services policy

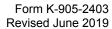
Completion of this form is not required for allied health services such as physical therapy, occupational therapy, speech therapy, or dietary services.

**Directions:** The person taking the child or youth completes Section I of this form on each visit with a health care provider. When possible, Section II is completed by the health care provider.

If the health care provider is unable to complete Section II, the person taking the child or youth to the appointment completes Section II, signs his or her name, and checks the box labeled: *health care provider unable to complete*. The health care provider may attach medical records or other information to this form in lieu of completing Section II.

The caregiver provides a copy of the completed form to the CPS caseworker to file in the case record.

Child's Name:	Date of Birth:		Person Identification (PID) Number:		Appointment Date:			
			I		1			
Caregiver can be a foster parent, relative, non-relative, or representative of a residential operation who is taking the child to the health care provider.								
Caregiver Name:		Phone N	Number:	Agency:				
Address:		City:		State:		Zip Code:		
		1		1				
3-Day Medical Exam. (Required within three business days of removal with some exceptions, such as DFPS removal while child is in a hospital setting).								
Child or Youth with Primary Medical Needs. (Required within seven days before or three days after placement date).								
Initial Child and Adolescent Needs and Strengths (CANS) Assessment. (Required within 30 days of entering DFPS conservatorship).								
Child and Adolescent Needs and Strengths Update (CANS) Assessment. (Required annually; may be required more frequently in some areas).								
Initial Texas Health Steps Medical Checkup. (Required within 30 days of entering DFPS conservatorship).								
Routine Texas Health Steps Dental Checkup. (Required every six months or as recommended by a dentist).								



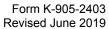


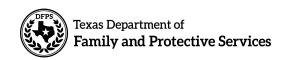
X

Other Dental Checkup. Reason:								
Vision Check	Hearing Check							
ER Visit – Reason:								
Specialty Visit: Re	eason:							
Illness, injury or accident or other follow-up visit. (Describe the injury, accident or illness, including the date and time of the incident.)								
No Yes (L	ist) Caregiver Comments:							
Medication	Dosage	Prescribed for	Instructions					
Caregiver Comments:								
caregiver comments.								
DFPS Staff or Caregiver Signature:		Date Signed:						



Child or Youth's Name:				Date	Date of Birth:			Appointment Date:				
Child	or youth	refused	d appointme	nt								
VITALS:												
Years:	Years: Months: Weeks:		Tempe	Temperature:		Pulse:		Respirations:		Blood Pressure:		
Height:	%:		Weight:	%:		Head Circ	cumference: %:		BMI: %:			
VISION S				70.			70.		70.			
Not o		Child	or vouth un	able to d	comply with	screening		Refused				
11000	Not done Child or youth unable to 500			1000			2000		4000			
	R		300				2555					
	L											
DIAGNOSES:												
Well Child or No Dental Problems Other (list):												
NEW OR CHANGED MEDICATIONS ONLY:												
	edication											
Name		Dosage	Presc	ribed fo	or Instru	uctions	DIS	continued		New	Changed	
VACCINES: Children and youth are prohibited from receiving vaccinations at the 3-Day Medical Exam unless an								ınless an				
emergency	y situation	requir	es tetanus v	accinati	on.							
None Administered												





	HIB PCV ovirus Influen:	Td MMR za Pneumo	Varicella ovax	Нер А	Нер В		
REFFERRED TO:							
None Necessary							
ECI (Early Childhood Intervent	ion) Speech	Therapy O	ccupational The	rapy	Physical Therapy		
Specialist (Type): Other (Type)							
FOLLOW-UP:							
None Necessary							
Return Visit: When and Why							
Provider Comments:							
Provider Signature:		Clinic Name:		Pho	ne:		
X							
Printed Name:	Address:				Fax:		
Date Signed:	City, State, Zip			1			
If Section II is not completed by a medical or dental provider, the caregiver sign below.							
Caregiver Signature:		Date Signed	d:				
x							
The health care provider was unable to complete this form.							

DFPS values your privacy. For more information, read our Privacy and Security Policy.