TX DEPT OF FAMILY 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):

|  |
| --- |
|       |
|       |

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| **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:** |       |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Height:** |       | **%:** |       |
| **Weight:** |       | **%:** |       |
| **Head Circ:** |       | **%:** |       |
| **BMI:** |       | **%:** |       |

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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **VISION & HEARING:** | VisionScreen | **R** 20/   \_\_\_ **L** 20/   \_\_[ ]  no glasses [ ]  glasses[ ]  didn’t bring glasses | [ ]  not done [ ]  too many prompts [ ]  refused | HearingScreen |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | **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      |

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