Health Care Program for Children in Foster Care (HCPCFC)
Foster Care Medical (Specialty) Contact Form

A DIVISION OF HEALTH CARE SERVICES AGENCY

San Joaquin County Public Health Services — health grows here

Submit to the HCPCFC Program within 5 business days of the examination – Fax: 209-932-2638

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system. For questions, call 209-468-1408.

Patient Name (Last) (First) (Initial)	**Language**	**Date of Service** Month / Day / Year

Birthdate Month / Day / Year	**Age(yr/m)**	**Sex**	**Gender**	**Patient's County of Residence**	**Telephone #** (Home or Cell)	**Alternate Phone #** (Work or Other)

Responsible Person (Name) (Street) (Apt/Space) (City) (Zip)

Ethnic Code ☐
1-White
2-Hispanic/Latino
3-Black/African American
4-American Indian/Alaska Native
5-Asian
6-Native Hawaiian/Other Pacific Islander
7-Other

Patient Eligibility:	County Code	Aid Code	Identification Number	**Next CHDP Exam** Month / Day / Year

Is the patient a Medi-Cal Managed Care Plan enrollee? ☐ Yes ☐ No

A. Medical Assessment and Referral Section

Type of Visit:

MEDICAL ☐ **Well Child Exam** ☐ **Immunization Visit** ☐ **Sick Visit/Urgent Care** ☐ **Reproductive Health** ☐ **Follow Up**

SPECIALTY/Dental _____ ☐ **Initial Consultation** ☐ **Follow Up**

Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health)

Height To nearest 0.1 cm	Height Percentile	**Weight** To nearest 0.1 kg	Weight Percentile	**BMI**	BMI Percentile	**Head Circumference**	Head Circ. Percentile

Blood Pressure	**Hemoglobin**	**Hematocrit**	**Vision Results** OD / OS / OU	**Hearing Results** R / L

Labs Ordered
☐ **CBC** ☐ **Lead** ☐ **Other:**_____

Date Labs Ordered | **Lab Results**

Any known **allergies** to medication/food/environment? ☐ **Y** ☐ **N** Please list:_____

ASSESSMENT/DIAGNOSIS:

Depression Screening: ☐ **Y** ☐ **N** **Substance Abuse Screening:** ☐ **Y** ☐ **N** **Tool Used (if any)?** _____

MEDICATIONS/TREATMENTS:
(DOSAGE/FREQUENCY)

If prescribed psychotropic medication was a
JV220 (A) completed? ☐ **Y** ☐ **N**
Was EKG completed? ☐ **Y** ☐ **N**
Were Labs completed? ☐ **Y** ☐ **N**

DEVELOPMENTAL SCREENING/ASSESSMENT: **Completed today?** ☐ **Y** ☐ **N**

Developmental tool used, if any: (Please attach a copy) ☐ **ASQ-3** ☐ **ASQ-SE** ☐ **Other** (Specify):_____

Age appropriate development? ☐ **Y** ☐ **N** **if NO, Indicate:** ☐ **Gross** ☐ **Fine** ☐ **Speech/Language** ☐ **Social/Emotional** ☐ **Cognitive**

Physical Growth ☐ **WNL** ☐ **Delayed**

_____

REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)

IMMUNIZATIONS
☐ **Copy of IZ Records Attached?**
Please check (☑) which immunizations have been given TODAY:

IPV 1☐ 2☐ 3☐ 4☐
DTaP 1☐ 2☐ 3☐ 4☐ 5☐
Td ☐
Tdap/Booster ☐
Hib 1☐ 2☐ 3☐ 4☐
MMR 1☐ 2☐
Hep B 1☐ 2☐ 3☐
Hep A 1☐ 2☐
VZV 1☐ 2☐
PCV 1☐ 2☐ 3☐ 4☐ 5☐
PCV13 ☐
MenACWY ☐
HPV 1☐ 2☐ 3☐
Influenza 1☐ 2☐
Rotavirus 1☐ 2☐ 3☐
Other:_____
☐ **Up to date** ☐ **Not up to date**

☐ **PPD** ☐ **TB Risk Assessment**
Date Given:_____
Date Read:_____
Results: ☐ **Negative** ☐ **Positive**
☐ **Return for PPD Read**
☐ **Lab ordered for QFT/IGRA**

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis
Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis
Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain
Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

☐ **Dental home referral** **Referred To and Contact Number:** _____

C. Provider Information

Service Location: Office Name, Address, Telephone and Fax Number

NPI Number

Provider Name (Print Name)

Provider Signature | **Date**

Follow up appointments needed? ☐ **Y** ☐ **N** **Date/Time**_____

Revised 9/2019

Forms may also be mailed to HCPCFC: Foster care Nursing, SJC Human Services Agency, P.O. Box 201056, Stockton, CA 95297-0106