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

Submit to the HCPCFC Program within 5 business days of the examination – Fax: 209-932-2638 or hsa-phn@sjgov.org
Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty). 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)

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

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

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 ______ **Type** (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health) ☐ Initial Consultation ☐ Follow Up
Ambulatory ☐ **Non-Ambulatory** ☐

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**

Over the Counter Medications (list) :

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)** ☐ **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**____________