North Carolina Department of Health and Human Services | Division of Social Services

Health Summary Form - Initial

Initial Visit for Infants/Children/Youth in DSS Custody*

Instructions: Providers complete this form at the time of the medical appointment within 7 days of the child's placement.

Copy given to_____ (caregiver) on____/____/_____by_____

Date of Visit: / / Patient's Name: D.O.B: / /

Patient's Medicaid ID Number: _____

Physical Examination: ATTACH Visit Summary with vitals, growth parameters, and exam findings and immunization record if available. You do not have to duplicate information on here if in attachments.

Current health conditions/issues (acute/chronic):

_____

_____

_____

Medications provided/prescribed:

_____

_____

_____

Immunizations (administered this visit):

_____

_____

Allergies:

_____

_____

Referrals (specialty care/CC4C/home visits):

_____

_____

_____

Other concerns (home, school):

_____

_____

_____

Does the child have signs/symptoms of any **communicable disease** (i.e. hepatitis, TB, lice) that would pose a risk of transmission in a household setting? ☐ YES ☐ NO ☐ UNKNOWN

If yes, describe: _____

_____

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PSYCHOTROPIC MEDICATION REVIEW REQUESTED: ☐ YES ☐ NO

Treatment plan (follow-up appointment/labs/testing/needed immunizations):

_____

_____

_____

Comments or instructions for DSS/caregivers/school personnel:

_____

_____

30-day Comprehensive Visit date/time: ____/_____/_____ ____:_____ AM/PM

Provider name: _____ (stamp)

Provider signature: _____

THIS FORM & REQUESTED ATTACHMENTS FAXED/SENT TO DSS & CCNC/CC4C CARE MANAGER:

DATE: / / INITIALS: _____

*Adapted from AAP's Healthy Foster Care America Health Summary Form