Solano County Health & Social Services
Child Welfare/ Foster Care Public Health Nurse
275 Beck Avenue, MS 5-230
Fairfield, CA 94533-6804
FAX: 707-784-8480 or EMAIL: FCPHN@solanocounty.com

HEALTH CONTACT FORM

TODAY'S DATE: _____

CHILD'S NAME: _____ DOB: _____

CARETAKER: _____ PHONE NO: _____

SOCIAL WORKER: _____ PHONE NO: _____

EXAM TYPE	**REFERRAL MADE:**	**SPECIALTY EXAM**
( ) Well Child Exam	( ) None ( ) CCS ( ) Specialist	( ) Type:_____
( ) Sick Visit Exam/Urgent Care Visit	( ) Type: _____	( ) Initial Visit
( ) Follow-up	( ) Referred to:_____	( ) Follow-up

MANDATORY FIELD		
*Height: _____ (_____ %)	Vision: R:_____ L:_____ B:_____	Hgb: Date done: _____ Results:_____
*Weight: _____ (_____ %)	Hearing: R:_____ L:_____	Lead: Date done:_____ Results:_____
*BMI: _____ Head Circ: _____	( ) Failed Hearing ( ) Referred:_____	

Medical Conditions:

Treatment Plan:

Dental Assessment:

( ) Referred to a Dental Home

( ) Class 1: No visible Problems
( ) Class 2: Visible Decay, small carious lesions or gingivitis
( ) Class 3: Urgent-pain, abscess, large carious lesions or extreme gingivitis

( ) Yes-Fluoride Varnish Applied
( ) No- Reason: ( ) Parent refusal
( ) No Teeth
( ) Other:_____

IMMUNIZATIONS: (Check ones given today)

DTaP, Tdap, Td 1____ 2_____ 3_____ 4_____ 5____ 6 _____
IPV 1_____ 2_____ 3_____ 4_____
Hep A 1_____ 2_____
Hep B 1_____ 2_____ 3_____
HIB 1_____ 2_____ 3_____ 4_____
MMR 1_____ 2_____
PCV 1_____ 2_____ 3_____ 4_____ PVC 13_____
VZV 1_____ 2_____
MVC4 1_____ 2_____
FLU _____
HPV 1_____ 2_____ 3_____
ROTA 1_____ 2_____ 3_____
RSV 1_____
PPD Date Given:_____ Date Read:_____ Results_____
Other: _____
Up-to-Date: _____

***DEVELOPMENTAL ASSESSMENT:**

( ) Age Appropriate Development: ( ) YES ( ) NO

( )Physical Growth ( ) Normal ( ) Delayed_____
_____
( ) Developmentally Delayed:
( ) Motor: ( )Gross ( )Fine
( ) Speech or Language ( )Social/Emotional
( ) Cognitive

CURRENT MEDICATIONS:

( ) None
( ) Prescription:_____
_____
( ) OTC_____

( ) Psychotropic:_____
_____

PROVIDER NAME: _____ **Phone NO:** _____
PROVIDER SIGNATURE: _____ **DATE:** _____
CLINIC: (STAMP) **FAX NO:** _____

Return to: FAX to (707) 784-8480 or EMAIL to: FCPHN@solanocounty.com or Mail in pre-paid envelope
Distribution: Original (Social Worker) - Electronic Copy (Foster Care PHN) - Copy (Placement Home)