Utah DHS-DCFS
Revised June 1998

HEALTH VISIT REPORT

(In lieu of completing health visit report may attach 2 copies of Completed Report from Health Care Provider)

RECEIVED AUG 2 Form 984

TO BE COMPLETED PRIOR TO APPOINTMENT *(Out of Home provider or worker to complete this section)*

Child's Name: Jordan Bierly | Date of Visit: 08/01/01 | Health Care Provider *(Name and Address)*: Alpine Vision 3620 W 3500 S

Child's Birthdate 04/09/93 | Current Age 8 | Client ID#

Natural Parent Notified of Appointment on (date)_____ and Invited to Attend Yes ☐ No ☐

Person(s) Attending Visit with Child: ☒ Foster Parent ☐ Natural Parent ☐ Caseworker ☐ Tracker ☐ Assistant Caseworker ☐ Other: _____

TYPE OF VISIT / VISIT INFORMATION *(Health Care Provider complete this section or attach 2 copies of Completed Report from Health Care Provider)*

- ☐ Well Child/CHEC
- ☐ Initial Health Screen
- ☐ Mental Health
- ☐ Dental Exam/Prophy
- ☐ Dental Follow Up
- ☒ Vision Exam
- ☐ Sick/Emergency
- ☐ Other (specify)_____

Significant History

History of: Sex Abuse Physical Abuse Abandonment Neglect Prenatal Drug Abuse Other _____

Chronic Illness: Diabetes

Mental Health: Developmental Delay Learning Disability Depression Substance Abuse Suicidal Ideation ADD/ADHD Behavioral Problems

Current Med(s)/Dose: _____

Allergies: NO YES: Sulfa PCN Other_____

Immunizations Status: Current Not Current Unknown

COMPLETE RELEVANT SECTIONS ONLY

Ht____ Wt____ OFC____ T____ BP____ HR____ RR____ Hct____

UA: Normal Abnormal____ Lead Screen____ PKU: Yes No HCG: + - Other Lab tests as appropriate to age and risk: _____

N = NORMAL D = DEFERRED	N	D	Abnormal with Comments
GENERAL			
GROWTH			
VISION/EYES	✓		Jordan complains of
HEARING			blurred vision. Possibly
SKIN			due to high blood sugars.
ORAL			No glasses needed but
EAR, NOSE, THROAT			recheck in 6 month if
PULMONARY			blurred vision continues
CARDIOVASCULAR			and after sugars are
GASTROINTESTINAL			lowered consistently.
GENITAL-URINARY			
MUSCULO-SKELETAL			I cannot see
NEUROLOGICAL			till Nov. 5th 2001
BEHAVIOR			2 months later than
SPEECH/LANGUAGE			he was supposed
PSYCHOSOCIAL			to be seen.

ASSESSMENT

DX 1._____

2._____

3._____

PLAN (include RX)

RECEIVED 8-7-01
USSDS/SAFE
ACCESS
CASE [illegible] Harris
HCC CH

IMMUNIZATIONS (Given at this Visit)

DTP OPV IPV PPD MMR HBV Hib dT Other_____

REFERRALS

Standard Referrals Needed: Vision Dental Mental Health

*Other Referrals Needed:*_____(Specialty/Provider)

*Made appointment with:*_____*on*_____

NEXT APPOINTMENT _____

Health Provider Signature: *(Please print name clearly and sign)* Chris Trapel O.D. | Date: 08/01/01

Distribution: White Copy - DCFS Case File Pink Copy - Data Entry / RHCC at DCFS Yellow Copy - Traveling Record (OVER)