Utah DHS-DCFS
Revised March 2000

HEALTH VISIT REPORT

Keller

Form 984

Child's Name:	Date of Visit:	Child's Date of Birth:	Child's Current Age:
JORDAN BIERLY	10/2/00	4/9/93	7 5/12

Client ID#:	Caseworker Name:	Health Care Provider (Name and Address):
	BARRY RICHARDS	DANA HARDIN/PCMC 100 NORTH MEDICAL DRIVE Salt Lake City UT

Natural Parent Notified of Appointment on (date) 10/2/00 and Invited to Attend ☑ Yes ☐ No ☐

Person(s) Attending Visit with Child: ☑ Foster Parent ☑ Natural Parent ☑ Caseworker ☐ Tracker ☐ Assistant Caseworker ☑ Other: EHC NURSE

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 Assessment
- ☐ Mental Health
- ☐ Dental Exam
- ☐ Dental Treatment
- ☐ Vision Exam
- ☐ Episodic/Sick/Emergency
- ☐ Other (specify)_____

Significant History

History of: Sex Abuse Physical Abuse Abandonment Neglect Drug Abuse: prenatal/parental Other medical Neglect

Chronic Illness: type 1 diabetes

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

Current Med(s)/Dose: Insulin NPH in AM ; at dinner

Allergies: NO YES: Sulfa PCN Other NKA

COMPLETE RELEVANT SECTIONS ONLY

Ht 119.5 % Wt 21.5 % OFC ____ % T ____ BP ____ HR ____ RR ____ Hb A1c 10.52!

PPD Hct/Hgb ____ UA: Normal Abnormal ____ Lead Screen ____ PKU: Yes No HCG: + - Other Lab: ____

N = NORMAL A = ABNORMAL D = DEFERRED	N	A	D	Comments
GENERAL	✓			
GROWTH		✓		Poor growth
VISION/EYES	✓			
HEARING	✓			
SKIN	✓			
ORAL	✓			
EAR, NOSE, THROAT	✓			10-16-00
PULMONARY	✓			
CARDIOVASCULAR	✓			SD
GASTROINTESTINAL	✓			
GENITOURINARY	✓			
MUSCULOSKELETAL	✓			
NEUROLOGICAL	✓			BF
BEHAVIOR		✓		Anxious
SPEECH/LANGUAGE	✓			
PSYCHOSOCIAL		✓		possible depression

RECEIVED
USSDS/SAFE
ACCESS
CASEWORKER
HCC

DIAGNOSIS

Type 1 diabetes out of control

PLAN/TREATMENT (include RX)

Hospitalize ? start new insulin regimen ; review all medical education w/ mother & family. Psychological assessment / social work mediation. Follow up w/ social work & w/ diabetes clinic after discharge

IMMUNIZATIONS (Given at this Visit)

DTaP IPV MMR Hep B Hib Td Hep A Varicella Other UTD

REFERRALS Vision Dental Mental Health

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

Made appointment with: _____ *on* _____

NEXT APPOINTMENT to be determined ~~date~~ hospitalized

Health Provider Signature: *(Please print name clearly and sign)* Date:

(Dana S. Hardin MD) 10/1/00

Distribution: White Copy - DCFS Case File Pink Copy - Data Entry / Health Care Team at DCFS Yellow Copy - Traveling Record