THE MATCH PROGRAM AT BCDSS **HEALTH VISIT REPORT FORM**

Name of Health Care Provider:	Child's Name:
Facility (Name and Address):	Child's DOB:
Telephone #:	Date of Visit:

INSTRUCTIONS TO HEALTH CARE PROVIDER: This form will be used to identify additional medical, dental, mental health, developmental, or educational services for the above named child. Please complete legibly and in lay terms so that foster care workers and foster parents can follow the recommendations. **A copy of your visit record from today's visit and any available immunization records, problem list, or medication list may be given instead of completing this form.**

TYPE OF VISIT (See Back of Form for Instructions about Visit Types):

☐ Initial Health Screen/Placement
☐ Comprehensive Medical Exam/EPSDT/Well Child Exam
☐ Sick/Emergency Exam
☐ Dental Exam
☐ Mental Health Visit

VISIT INFORMATION:

DIAGNOSIS (A problem list may be attached if all current diagnoses are included):

ASSESSMENT:

MEDICATIONS (A medication list may be attached if all new medications or medication changes are indicated):

Check if New Medication	Check if Dosage Change	Medication Name	Reason for Medication	Dosage/Frequency

IMMUNIZATIONS /TESTS/ TREATMENTS GIVEN:

RECOMMENDATIONS:

Recommendation/Referral/Follow-Up	Reason	Expected Timeframe

Health Care Provider's Signature **Date**

*FAX COMPLETED FORM AND ANY ADDITIONAL DOCUMENTATION TO THE MATCH PROGRAM AT 443-403-0696.