Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Foster Care Initial Health Screen

			DATE OF EXAMINATION
CHILD'S NAME (LAST, FIRST, MIDDLE INITIAL)			DATE OF BIRTH
BROUGHT IN BY (NAME): ☐ Social Worker ☐ Foster Parent ☐ Other:			CONTACT TELEPHONE NUMBER
ALLERGIES		WEIGHT (LBS/KG)	PERCENTILE
		HEIGHT (FT/IN/CM)	PERCENTILE
BMI	PERCENTILE	HEAD SIZE (IN/CM)	PERCENTILE
		BLOOD PRESSURE	TEMPERATURE

What is the source of medical information you used during this visit?

☐ Medical records ☐ Child Information form ☐ None ☐ Child ☐ Social worker ☐ Caregiver ☐ Other:

CHIEF COMPLAINT

Does the child have physical signs or symptoms compatible with abuse or neglect? ☐ Yes ☐ No

PROBLEM LIST

☐ Asthma/allergies
☐ Unknown
☐ Ear infection/sinusitis
☐ Eczema/skin problems
☐ Heart disease
☐ Other (list):
☐ Neurol/seizures
☐ Developmental delay
☐ Behavior
☐ Mental health
☐ Kidney problems

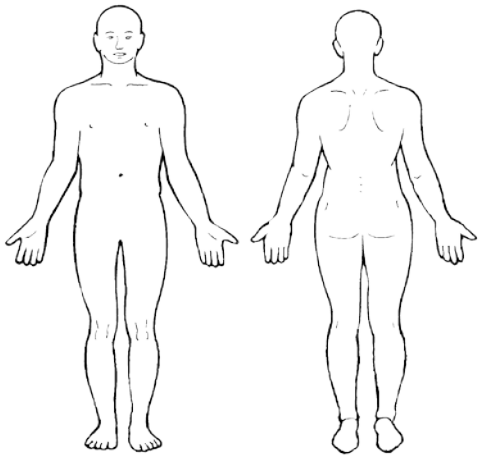
IMMUNIZATIONS

☐ Up to date ☐ Unknown

DUE FOR

MEDICATIONS

Use this area to show any marks bruises and/or scars.



REVIEW OF SYSTEMS	N	A		N	A		N	A
General appearance	☐	☐	Development	☐	☐	GU	☐	☐
HEENT	☐	☐	Other	☐	☐	Neuro	☐	☐
RESP	☐	☐	Skin	☐	☐	Mental health	☐	☐
GI	☐	☐	Dental	☐	☐			
Musc/skel	☐	☐	Heart	☐	☐			

DETAILS OF ABNORMAL FINDINGS

PHYSICAL	N	A		N	A		N	A
General Appearance	☐	☐	Musc/skel	☐	☐	Lymph	☐	☐
Eyes	☐	☐	Skin	☐	☐	GU If medically indicated	☐	☐
Nose, Mouth, Teeth	☐	☐	Head/neck	☐	☐	Neurol	☐	☐
Heart	☐	☐	Ears	☐	☐	Mental Status	☐	☐
Abdomen	☐	☐	Lungs	☐	☐			

DETAILS OF ABNORMAL FINDINGS

ASSESSMENT

Chronic Diagnosis: None 1. _____ 2. _____ 3. _____

Acute Diagnosis: None 1. _____ 2. _____ 3. _____

COMMENTS

Plan of Care for this child will be:

RX

OTHER

FOLLOW-UP

☐ PRN ☐ EPSDT ☐ Acute follow up in_____day(s)

Chronic care management follow up in_____ ☐ days ☐ weeks ☐ months

REFERRALS TO		HOW SOON
PROVIDER NAME	SIGNATURE	DATE
CLINIC NAME	TELEPHONE NUMBER	FAX NUMBER

DISTRIBUTION: Original – Physician Yellow – HCA Pink – Foster Parent/Guardian