Health Care Program for Children in Foster Care (HCPCFC)
Foster Care Medical (Specialty) Contact Form

Submit to the County HCPCFC Program within 5 business days of the examination - eFax: (661) 633-7046

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system.

Patient Name (Last) (First) (Initial) | Language | Date of Service Month Day Year

Birthdate Month Day Year | Age(yr/m) | Sex | Gender | Patient's County of Residence | Telephone # (Home or Cell) | Alternate Phone # (Work or Other)

Responsible Person (Name) (Street) (Apt/Space) (City) (Zip)

Patient Eligibility: County Code | Aid Code | Identification Number | Next CHDP Exam Month Day Year

Health Coverage: ☐ Medi-Cal FFS ☐ Gateway ☐ Managed Care Plan _____

Ethnic Code ☐
1-American Indian
2-Asian
3-Black
4-Filipino
5-Mex. Amer/Hispanic
6-White
7-Pacific Islander
8-Other

A. Medical Assessment and Referral Section

Type of Visit:
MEDICAL ☐ Well Child Exam ☐ Immunization Visit ☐ Sick Visit/Urgent Care ☐ Reproductive Health ☐ Follow Up
SPECIALTY _____ Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health) ☐ Initial Consultation ☐ Follow Up

Height To nearest 0.1 cm	Height Percentile	Weight To nearest 0.1 kg	Weight Percentile	BMI	BMI Percentile	Head Circumference	Head Circ. Percentile

Blood Pressure	Hemoglobin	Hematocrit	Vision Results OD OS OU	Hearing Results R L

Labs Ordered ☐ CBC ☐ Lead ☐ Other:_____ | Date Labs Ordered | Lab Results

Any known allergies to medication/food/environment? ☐ Y ☐ N Please list:_____

ASSESSMENT/DIAGNOSIS:

Depression Screening: ☐ Y ☐ N Substance Abuse Screening: ☐ Y ☐ N Tool Used (if any)? _____

MEDICATIONS/TREATMENTS:
(DOSAGE/FREQUENCY)

If prescribed psychotropic medication was a JV220 (A) completed? ☐ Y ☐ N
Was EKG completed? ☐ Y ☐ N
Were Labs completed? ☐ Y ☐ N

DEVELOPMENTAL SCREENING/ASSESSMENT: Completed today? ☐ Y ☐ N
Developmental tool used, if any: (Please attach a copy) ☐ ASQ-3 ☐ ASQ-SE ☐ Other (Specify):_____
Age appropriate development? ☐ Y ☐ N if NO, Indicate: ☐ Gross ☐ Fine ☐ Speech/Language ☐ Social/Emotional ☐ Cognitive
Physical Growth ☐ WNL ☐ Delayed _____

REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)

IMMUNIZATIONS
☐ Copy of IZ Records Attached?
Please check (☑) which immunizations have been given TODAY:

IPV	1☐	2☐	3☐	4☐	
DTaP	1☐	2☐	3☐	4☐	5☐
Td	☐				
Tdap/Booster	☐				
Hib	1☐	2☐	3☐	4☐	
MMR	1☐	2☐			
Hep B	1☐	2☐	3☐		
Hep A	1☐	2☐			
VZV	1☐	2☐			
PCV	1☐	2☐	3☐	4☐	5☐
PCV13	☐				
MenACWY	☐				
HPV	1☐	2☐	3☐		
Influenza	1☐	2☐			
Rotavirus	1☐	2☐	3☐		

Other:_____
☐ Up to date ☐ Not up to date

☐ PPD ☐ TB Risk Assessment
Date Given:_____
Date Read:_____
Results: ☐ Negative ☐ Positive
☐ Return for PPD Read
☐ Lab ordered for QFT/IGRA

B. Dental Assessment and Referral Section

☐ Dental home referral Referred To and Contact Number: _____

☐ **Class I:** No Visible Problems
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis
Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis
Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain
Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

C. Provider Information

Service Location: Office Name, Address, Telephone/Fax Number

NPI Number

Provider Name (Print Name)

Provider Signature | Date

Follow up appointments needed? ☐ Y ☐ N Date/Time_____