

Family, Youth and Children’s Services

HEALTH CONTACT FORM

Please complete this for EVERY medical, dental, clinic or specialty visit.

FAX THIS COMPLETED FORM ATTN TO: JAMIE OTT AT 565-8677 & PAT MULLOOL at 565-4399

Section 1 – to be completed by Foster Parent:

Child’s name: _____	DOB: _____
Foster Parent: _____	Social Worker: _____
Health Care Provider: _____	Phone: _____
Provider Address: _____	
Reason for Visit: _____	Date: _____

Section 2 – to be completed by Health Care Provider:

DIAGNOSIS: _____ Wt: _____ Ht: _____ HC: _____

TREATMENT PLAN/INSTRUCTIONS:

Immunizations given TODAY, if any: _____

FOLLOW UP APPOINTMENT OR REFERRAL:

Heath Care Provider (print): _____ Date: _____

Signature: _____

If faxed, the accompanying document may contain confidential information intended for the person named on this form. If you are not authorized to use, disclose or copy any of the information, please immediately notify us by telephone of the erroneous transmission and dispose of the documents in confidential shredding. Please call Sonoma County Human Services at (707) 565-4300.