Family, Youth and Children's Services ~ Servicios Para La Familia, Jovenes y Niños

HEALTH CONTACT FORM ~ FORMA DE CONTACTO DE SALUD

Please complete this for EVERY medical, dental, clinic or specialty visit and return to FY&C.
Favor de completer esta forma para CADA visita medica, dental, clinica o vista especializada. Regresen la forma completa a la FY&C.

Mail/Envie a: Public Health Nurse, PO Box 1539, Santa Rosa, CA 95402 or/o por FAX: Attn: PHN (707) 565-4298

Section/Sección 1–to be completed by Foster Parent/debe ser completa por el Padre de Crianza:

Child's name/Nombre del niño(a): ______________________

DOB/Fecha de Nacimiento: ____________ Foster Parent/Padre de Crianza: ____________

Social Worker/Trabajadora Social: ______________________

Health Care Provider/Proveedor de Salud: ____________ Phone/Teléfono: ____________

Provider Address/Dirección del Proveedor: ______________________

Reason for Visit/Razón de la visita: ____________ Date/Fecha: ____________

Section/Sección 2 – to be completed by Health Care Provider/debe ser completa por el Proveedor de Salud:

Type of Visit: ☐ Medical ☐ Dental ☐ Mental Health

Purpose of Visit: ☐ Routine Comprehensive (Well Child) Ht.: ________ Wt. ________ B.P. ________

☐ Tx Ongoing ☐ Tx Completed

☐ Follow Up ☐ Specialist Visit HC (if infant): ________

☐ Sick Visit ☐ Family Therapy

☐ Individual Therapy ☐ Group Therapy

☐ Other: ____________

Did Caregiver accompany child to visit? ☐ No ☐ Yes If yes, Caregiver's name: ____________

Dx: **ICD-10 (if easily available):**

Rx:

Was the child referred to another provider? ☐ No ☐ Yes (If yes, complete the following.)

Name of Provider: ____________ Specialty: ____________

To be seen by what date: ____________ Date of visit: ____________

Signature of Service Provider: ______________________

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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.