TULARE COUNTY HEALTH AND HUMAN SERVICES AGENCY
HEALTH CARE ENCOUNTER FORM

Health Care Provider: Please complete for any health care visit.

Date of Visit:__/__/__ Name: DOB:

Growth:	**Ht:**	**Wt:**	**HC:**
Diagnosis:			
Treatment/ Medication:			
Immunization Given:			☐ **TB Skin Test** **Result (+)☐ (-)☐**
Tests:			
Additional Comments:	☐ **Hgb:_____** ☐ **Lead Level:_____** **VISION:** ☐ **Normal** ☐ **Abnormal** **Hearing:** ☐ **Normal** ☐ **Abnormal** ****Ambulatory** ☐**Yes**☐**No** ☐**Child has a chronic condition** **Other:**		

TYPE OF VISIT (Check one): ☐**Medical** ☐**Dental** ☐**Mental Health**

PURPOSE OF VISIT (Check One): ☐**Routine CHDP Exam** ☐**Routine Dental Exam**
☐ **Sick Visit** ☐**Follow-Up** ☐ **Specialist Visit**

☐**Referral Made to:_____**

Currently Receiving Services From: ☐**Children's Services** ☐**Regional Center** ☐**Other**

Signature of Provider:_____Telephone:_____

Name of Provider:_____ Fax No:_____

PLEASE RETURN TO:
HEALTHCARE PROGRAM FOR CHILDREN IN FOSTER CARE
CHILD WELFARE SERVICES 3500 W. Mineral King, Ste.B, Visalia, CA 93291
OR FAX TO (559) 730-2523 OR Email to CWS_Nurses@tularecounty.ca.gov
FOR QUESTIONS PLEASE CALL (559) 623-0530

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