RECORD OF MEDICAL TREATMENT

State Form 45092 (R3 / 9-05) / CW 3320

The information contained on this form is **CONFIDENTIAL** according to IC 31-34 / IC 31-37 / 42 USC 622.

Name of child	Date of birth *(month, day, year)*	Case number
Name of foster parent	Date of treatment *(month, day, year)*	Medicaid / Insurance policy number
Name of local DCS office		
Address of local DCS office *(street, city, state and ZIP code)*		
Name of family case manager		Telephone number of family case manager ( )

PRESENTING PROBLEM

OBSERVATIONS

TREATMENT

GENERAL COMMENTS

RECOMMENDATIONS FOR FUTURE HEALTH CARE AND FOLLOW-UP TREATMENT

Signature of provider	Date signed *(month, day, year)*

DISTRIBUTION: White - **Provider;** Canary - **local DCS office;** Pink - **Foster parent**

Identifying information of child patient is on front of form.

Allergies ______NKA **Please list:** ____________________
Current Meds/Vitamins: ____________________
Height: _______ **Weight:** ____________ **BP (age 3 and up):**___________**Pulse:**________
Head Circ (0-24 mos): ________________ **BMI (9 mos to 20 yrs):**________ **Resp:**________

Screenings:
Dental Screen: Observations: ____________________
Vision Screen: Corrected/Uncorrected (circle one) Left eye_______/_______ Right Eye____/______
Physical Activity: ____________________
Hearing Screen: Within normal limits? YES/ NO
Speech: Within Normal Limits? YES/NO **Nutritional Screen:** Adequate/ Inadequate
Growth/Development Screen: Age Appropriate? YES/NO

Physical Examinations

Are these normal?	Normal	Describe Abnormal Findings:
Skin/Hair/Nails Tuberculin Test		
Ears		
Eyes		
Nose/Mouth/Throat		
Teeth/Gums		
Head/Neck		
Respiratory		
Cardiovascular		
Abdomen/Gastrointestinal		
Endocrine		
Genitourinary/Breast (if applicable)		
Pelvic Exam (if applicable)		
Extremeties/Musculoskeletal ROM		
Back/Hips		
Neurological		

Labs Ordered:

Lead Risk? YES/NO
Assessment Summary & Treatment Plan: Describe on front of form under "TREATMENT"
Immunizations due or administered during the visit:

Referrals:
☐ WIC ☐ Dental ☐ Vision ☐ Hearing ☐ Developmental ☐ Other (please specify on front of form)

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Clinician Printed Name ***Signature on front of Record of Medical Treatment Form**