North Carolina Department of Health and Human Services | Division of Social Services

Health History Form

Copy given to_____ (caregiver) on____/____/_____by_____

FORM COMPLETION
DSS caseworkers should complete this form and fax/send it to the medical home provider at least **one week prior** to the scheduled 30-day Comprehensive Visit. Please see DSS-5207ins Health History Form Instructions to complete appropriately.

I. CONTACT INFORMATION

COUNTY DSS CONTACT

Name_____

Phone _____Fax_____

Email_____County_____

CC4C/CCNC NETWORK CONTACT

Name_____Phone_____

Email_____

GUARDIAN AD LITEM (if assigned)

Name_____Phone_____

Email_____

INSURANCE AND PROVIDER INFORMATION

Child's Name_____D.O.B.__/__/__ Sex___ Race/Ethnicity_____

Child's Medicaid ID Number_____

Other Insurance_____

Current/Most Recent Medical Home/Primary Care Provider: ☐ Unknown. ☐ No history of care.

Provider_____Practice_____

Address_____County_____

Phone _____Fax_____Email_____

Date of last physical exam_____

Medical Home Assignment: ☐ Same as above. ☐ Assigned to the following practice:

Provider_____Practice_____

Address_____County_____

Phone _____Fax_____Email_____

Dental Care Provider: ☐ Unknown. ☐ No history of dental care.

Practice_____

Address_____County_____

Phone _____Fax_____Email_____

Date of last dental exam_____

Specialty Care/Behavioral Health Providers/Other Health Professionals (OT, PT, Speech):

Provider/Credentials_____Practice_____

Address_____County_____

Phone _____Fax_____Email_____

Date of last visit_____

Provider/Credentials_____Practice_____

Address_____County_____

Phone _____Fax_____Email_____

Date of last visit_____

II. CURRENT PLACEMENT INFORMATION

Date of entry into DSS care____/____/_____Total number of lifetime placements_____

Length of time the child has been in *this* home_____

Reason for placement (or change of placement) _____

_____

People in this placement home and relationship to the child (include names of foster parents)

_____

_____

Are the siblings placed together? ☐ Yes ☐ No ☐ No siblings

Are the siblings able to have contact? ☐ Yes ☐ No

Are biological parents permitted contact? ☐ Yes ☐ No

Any restrictions or safety concerns?

_____

III. MEDICAL AND DENTAL HISTORY/CONCERNS (from biological parent or previous records)

Include significant illness, injury, chronic condition, recent ER visits, hospitalization, surgery, or dental concerns:

_____

_____

_____

Does the child have signs/symptoms of any **communicable disease** (i.e. hepatitis, TB, lice) that would pose a risk of transmission in a household setting? ☐ YES ☐ NO ☐ UNKNOWN

If yes, describe: _____

Special dietary needs/formula/WIC_____

Glasses/contacts required? ☐ YES ☐ NO Does he/she have them now? ☐ YES ☐ NO

Hearing aid required? ☐ YES ☐ NO Does he/she have them now? ☐ YES ☐ NO

Other medical equipment required (i.e. spacer for inhaler, insulin pump, oxygen, bath aids,

wheelchair, stander, communication device)? _____

KNOWN ALLERGIES/DRUG SENSITIVITIES

Allergy/Drug_____Reaction_____

Allergy/Drug_____Reaction_____

Allergy/Drug_____Reaction_____

Does the child have an EpiPen or other medication for response? ☐ YES ☐ NO

IV. CURRENT MEDICATIONS

MEDICATION	DOSAGE/FREQUENCY	WHY PRESCRIBED?	NEED REFILL?

V. DEVELOPMENTAL, BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE ABUSE HISTORY

Concerns/diagnoses/interventions/treatment_____

_____

_____

Describe child's involvement with the juvenile justice system (if any) _____

_____

CHILD CARE/EDUCATION INFORMATION

NAME OF SCHOOL OR CHILD CARE FACILITY AND PHONE NUMBER	CURRENT GRADE	CONCERNS	SERVICES (i.e. speech, OT)

VI. FAMILY HEALTH & BIRTH HISTORY

Household composition before coming into care _____

_____

Summary of relevant health status/conditions/genetic disorders of biological parents & siblings

_____

_____

Is there a history of family violence? ☐ Yes ☐ No

Is there a history of alcohol or substance abuse? ☐ Yes ☐ No

Prenatal or perinatal risk factors_____

_____

Name/location of child's birth hospital_____

_____

VII. ATTACHMENTS:

***IF AVAILABLE,* please attach the following:**

FROM BIOLOGICAL PARENT:

- Any medical records
- Age-appropriate developmental screening record—for example:
  - ASQ-3 (Ages and Stages Questionnaire) or PEDS (age 0-5 years)
  - PSC (Pediatric Symptom Checklist) (age 6-10 years)
  - Bright Futures Supplemental Questionnaire or PSC-Y (completed by adolescent, age 11-21 years)

  For copies of these tools, please contact your CC4C/CCNC Network Care Manager or medical home provider
  For further guidance, please see *Best Practices for DSS Social Workers (http://www.ncpeds.org/county-dept-social-services-professionals-online-library)*

FROM HEALTH CARE PROVIDERS:

- Discharge summaries from hospital of birth and other hospitalizations/ER visits
- Growth chart/record from primary care provider
- Medical records (or documentation from CCNC's Provider Portal) related to health conditions, medications, allergies, and immunizations
- Care plans for asthma / diabetes / or other chronic health conditions
- Screenings/measures to evaluate social-emotional, behavioral concerns
- Therapy or specialty provider reports (i.e. speech, audiology, mental health)

FROM CDSA OR CHILD'S SCHOOL:

- Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP)

INITIAL VISIT completed (date):____/_____/_____

30-DAY COMPREHENSIVE VISIT scheduled for:____/_____/_____ at ___:_____AM/PM

THIS FORM (AND ATTACHMENTS) FAXED/SENT TO COMPREHENSIVE VISIT PROVIDER:

Provider name_____

Practice name_____

Fax number_____

DATE FAXED/SENT___/____/_____INITIALS_____