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

Health Summary Form - Comprehensive

30-day Comprehensive Visit for Infants/Children/Youth in DSS Custody

Instructions: Providers complete this form at the time of the comprehensive medical appointment. Please attach summary of visit and enter any information on the form that is not included in the summary.

Date of Visit: / / Patient's Name: D.O.B: / /

Patient's Medicaid ID Number: _____

COUNTY DSS CONTACT

Name_____

Phone _____Fax_____

Email_____County_____

MEDICAL HISTORY

Birth History

Location of birth (if hospital, name and location) _____

BW_____ Term___ Preterm____Gestation_____wks

Prenatal and perinatal risks _____

NICU: ☐ YES ☐ NO Detail_____

Acute illness or other health needs_____

_____

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: _____

_____

Chronic physical or mental health conditions (e.g., asthma, diabetes) *Attach copy of the care plan* _____

_____

Surgery/hospitalizations/ER visits (when/where/why) _____

_____

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Past injuries (what; when) _____

_____

Allergies/drug sensitivities (with type of reaction)_____

_____

Current medications	**Dosage**	**Why prescribed**	**Need refill?**
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

Medical equipment/supplies required_____

Nutritional assessment (diet/formula and any special needs) _____

VISION, HEARING

Visual impairment ☐ YES ☐ NO

Glasses/contacts required? ☐ YES ☐ NO

Hearing impairment ☐ YES ☐ NO

Hearing aid or cochlear implant ☐ YES ☐ NO Detail_____

ORAL HEALTH

Dental home ☐ YES ☐ NO

Dentist _____ Most recent visit _____

Current dental problems _____

Dental/oral health appointment scheduled_____

DEVELOPMENTAL HISTORY- *Attach screening records and growth chart(s)*

- **ASQ-3 (Ages and Stages Questionnaire) or PEDS (age 0-5)**
- **PSC (Pediatric Symptom Checklist) (age 6-10)**
- **Bright Futures Supp. Questionnaire or PSC-Y (completed by adolescent, age 11-21)**

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Disability/ delay/concern:

☐ Cognitive/learning_____

☐ Social-emotional_____

☐ Speech/language_____

☐ Fine motor_____

☐ Gross motor_____

☐ None

Intervention history: Current/on-going: Past:

☐ Speech & language therapy_____

☐ Occupational therapy_____

☐ Physical therapy _____

Results of Evaluation(s):_____ (Attach report(s))

For ages birth-3: (*If available, attach CDSA evaluation and Individualized Family Service Plan (IFSP)*

Referral to Care Coordination for Children (CC4C) ☐ YES ☐ NO

Referral to Early Intervention (Infant-Toddler Program) ☐ YES ☐ NO

Date of evaluation by the Children's Developmental Services Agency (CDSA) _____

For ages 3-5: (*If available, attach Individualized Education Plan (IEP))*

Referral to Care Coordination for Children (CC4C): ☐ YES ☐ NO

Referral to the Preschool Early Intervention Program: ☐ YES ☐ NO

Medical equipment and assistive technology: ☐ YES ☐ NO Detail _____

BEHAVIORAL/MENTAL HEALTH, SUBSTANCE ABUSE
(ASQ-SE, ECSA, SDQ, CESDC, SCARED, CRAFFT, and/or PHQ-9 for Adolescents, etc.)

Concerns_____

Screening results _____

Diagnosis ☐ YES ☐ NO Detail_____

Intervention and treatment history_____

EDUCATION (*If available, attach Individualized Education Plan (IEP) or Section 504 Plan)*

Child care or preschool_____

School_____ Grade_____ Grades repeated_____

Attendance problems? _____Reason_____

In- or out- of school suspension: ☐ YES ☐ NO Most recent? _____ How often? _____

Has the child received counseling at school? ☐ YES ☐ NO _____

Learning Issues:

- ☐ Learning disability
- ☐ ADHD
- ☐ Dysgraphia
- ☐ Intellectual disability
- ☐ Other

IEP? ☐ YES ☐ NO; 504 Plan? ☐ YES ☐ NO; Other accommodations/equipment needs at school?

_____

Extracurricular activities_____

FAMILY AND SOCIAL HISTORY

Provider comments--genetic/hereditary risk or in utero exposure_____

_____

Provider comments--current placement and visitation plan_____

_____

EVALUATION

Physical Examination: <u>ATTACH</u> Visit Summary with vitals, growth parameters and exam findings.

Screenings:

Vision: ☐ Pass ☐ Fail With glasses? ☐ YES ☐ NO Referral? _____

Hearing: ☐ Pass ☐ Fail

Development (circle one): ASQ/PEDS/MCHAT/PSC/Bright Futures Supplemental-Adolescent:
No Concerns_____ **At Risk/Concerns** _____

Specific Social-Emotional Screen: (e.g. ASQ-SW, ECSA, PHQ-9, Vanderbilt, SCARED)
No Concerns _____ **At Risk/Concerns** _____

Social/behavioral assessment (by integrated mental health professional, if applicable)

Overall assessment and diagnoses

PLAN/RECOMMENDATIONS

Follow-up treatment(s)/interventions for current health conditions including any labs, testing, or evaluation with dates/times

Referrals for specialist care, mental health, oral health or developmental services with dates/times

PLAN/RECOMMENDATIONS CONTINUED

Medications provided and/or prescribed today

Immunizations administered today

Immunizations still needed, if any

Limitations on physical activity

Diet/formula/WIC

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Special instructions for school and child care staff related to medications, allergies, diet_____

_____

Special instructions for foster parents/DSS contact_____

_____

_____

Well-Visit scheduled for (date/time):____/_____/_____ _____:_____AM/PM

Evaluation Team:

Primary Care Provider: _____

_____

Behavioral Health Provider: _____

_____

Specialty Providers: _____

Others: _____

ATTACHMENTS:

Visit Summary (EHR print-out)
Immunization Record
Age-appropriate developmental screening record, including growth record
Screenings/measures to evaluate social-emotional, behavioral concerns
Discharge summaries from hospitals from birth and other hospitalizations
Care plans for asthma / diabetes / other chronic health conditions
Medical records related to chronic health conditions, medications, or allergies
Therapy or specialty provider reports (examples: speech, audiology, mental health)

THIS FORM & ATTACHMENTS FAXED/SENT TO DSS & CCNC/CC4C CARE MANAGER:

DATE: _____

INITIALS: _____