PSYCHOLOGICAL/OTHER EXAMINATION FORM - INSTRUCTIONS

MEDICAL RECORD PROCEDURES FOR FOSTER CAREGIVERS (Caregiver is a Foster Parent, Relative, Group Home, or FFA).

The HEALTH & EDUCATION PASSPORT (HEP) BINDER accompanies each child at the time of placement. The Children's Social Worker (CSW) will review the HEP BINDER with you at each visit.

The Health and Education Passport must be taken to all medical visits, including the initial examination visit. The health care provider must record all current medical services and tests on the DCFS 561(c). Please add the completed forms to the child's HEP BINDER.

Immediately notify the child's CSW (or Supervising CSW, if the CSW is unavailable) when there is any change in the child's mental, medical and/or dental health that required urgent medical care.

If the child is removed from your care, the child's complete HEP BINDER, including the Immunization Record, shall be returned to the CSW *at the time of removal*, as the HEP BINDER must accompany the child upon replacement.

(To be completed by CSW/Caregiver. Please print legibly.)

CHILD's NAME: ____________________ DOB: __________ CASE #: __________ DATE PLACED: __________

CAREGIVER: ______________ (Phone) ____________ (FFA) ______________ (Phone) ____________

CSW: ____________________ (File #) __________ (Phone) ______________ (Fax) ______________

Data entered into CWS/CMS by: (Name) ______________________________ (Date) ______________

PSYCHOLOGICAL/OTHER EXAMINATION FORM

(To be completed by Mental Health or other Professional Health Care Provider, e.g., Psychiatrist, Psychologist, L.C.S.W., L.M.F.T., Speech Therapist, Physical Therapist, etc.)

OTHER HEALTH CARE PROVIDER

Date Child Seen: ________________ Name of Health Care Provider: ______________________________

Diagnosis/Treatment: (Treatment given. Medications Prescribed. Please attach copies of supporting documentation; test results, etc.)
(May be continued on additional pages if necessary. If so, provider to also sign and date additional pages.)

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Court authorization obtained for psychotropic medication(s)? ☐ ***Yes Date of Authorization*** ____________ ☐ ***N/A***

(Psychotropic medications for Court dependent children must be authorized by the Court. The Court authorization must be renewed every six months.)

If Yes, what psychotropic medication(s) prescribed? ______________________________

If follow-up care indicated, specify: ______________________________

Signature of Health Care Provider: ____________________(Date)__________

Address: ______________________________ Phone: ____________

(Signature Stamp Required)

Distribution: Pages 1, 2 and 3 to foster caregiver when child initially placed.
Page 4 to be filed in Psychological/Medical/Dental folder (purple).
When page 1 returned, file in Psychological/Medical/Dental folder.