Logo

Description automatically generated

**Medical Care Documentation Form**

Directions: The initial comprehensive health care screening upon admittance to Isaiah’s Place must include a physical examination, hearing screen, and vision screen, as appropriate to the child’s age and circumstances, developmental assessment (under the age of 5) and immunizations. A dental exam is required for youth ages 3 and older. An after-visit summary can be used in place of this form as long as the service provided is clearly documented.

Date of visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Physical Examination**

|  |  |  |
| --- | --- | --- |
| Height | Weight | Blood Pressure |
| Abdomen | Nose | Genitals |
| Ears | Mouth | Hernia |
| Eyes | Throat | Extremities |
| Heart | Lungs | Dermis |
| Lymph System | Posture/Spine |  |

* **Developmental Assessment**

|  |  |
| --- | --- |
| Gross and Fine Motor |  |
| Communication Skills |  |
| Self-Help Skills |  |
| Social-Emotional |  |
| Cognitive Skills |  |

|  |  |  |
| --- | --- | --- |
| **Hearing Screen**  (upon placement and as symptoms indicate) | **Vision Screen**  (upon placement and as symptoms indicate) | **Dental Examination** (every 6 months) |
| Too young, no concerns noted | Too young, no concerns noted | Cleaning/Exam |
| \_\_\_\_\_\_\_Right \_\_\_\_\_\_\_Left | \_\_\_\_\_\_\_Right \_\_\_\_\_\_\_Left | Other (specify): |

* **Psychiatric** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Therapy**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Other (Specify)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Visit Summary:**  Diagnosis:    Recommendations/Referrals:  Document client’s refusal to accept medical/dental treatment (if applicable)  List all medications prescribed:  **Signature and Credentials of Health Care Provider** **Date**  Print or stamp provider’s name, address and phone number: |