SAN BERNARDINO COUNTY CHILDREN and FAMILY SERVICES
REPORT OF MEDICAL / DENTAL EXAM

FOR HEALTH PASSPORT UPDATE
FAX or RETURN in the POSTPAID ENVELOPE
FFA must give original to social worker or PHN

PUBLIC HEALTH NURSE

CHILD: _____

CWS # _____

DOB: _____

WORKER NAME:_____

TO BE COMPLETED BY THE MEDICAL / DENTAL PROVIDER: ICD-9 (IF EASILY AVAILABLE)

DX:_____

RX:_____

Immunizations Given Today: (Please Check)

☐ DtaP #1	☐ IPV #1	☐ Hib #1	☐ Rota #1
☐ DtaP #2	☐ IPV #2	☐ Hib #2	☐ Rota #2
☐ DtaP #3	☐ IPV #3	☐ Hib #3	☐ Rota #3
☐ DtaP #4	☐ IPV #4	☐ Hib #4	
☐ DtaP #5			☐ MCV
☐ Td/Tdap #6	☐ MMR #1	☐ Varcella #1	
	☐ MMR #2	☐ Varcella #2	☐ HPV #1
			☐ HPV #2
☐ Hep B #1	☐ PCV #1	☐ HEP A #1	☐ HPV #3
☐ Hep B #2	☐ PCV #2	☐ HEP A #2	
☐ Hep B #3	☐ PCV #3		☐ Influenza
	☐ PCV #4		

Other Immunizations: _____

Results of tests done today

HEIGHT _____ HEARING _____
Head circ<2yr_____
WEIGHT _____ VISION _____
☐ BMI _____
☐ BP ____/____
☐ TB TEST _____ RESULTS _____

☐ HGB _____
☐ LEAD SCREENING: _____

OTHER TEST: _____

TYPE OF VISIT: ☐ Medical ☐ Dental ☐ Vision

Purpose:
☐ Routine Comprehensive (Well Child)
☐ Specialist visit ☐ Tx Completed
☐ Sick visit ☐ Tx Ongoing

☐ Follow up _____
_____
☐ Medication prescribed _____
_____

WAS CHILD REFERRED TO ANOTHER PROVIDER? ☐ NO ☐ YES (If Yes, please complete)

Name: _____ Specialty: _____

Address: _____ To be seen by what date: _____

_____ Telephone: ( )_____

Date of Service:_____

PROVIDER STAMP
HERE

Print Provider Name - Please Add Stamp:

_____

Address:_____

City/State: _____

Phone: (_____)_____

TDD – Telephone Services For The Hearing Impaired (909) 386-9780
Child and Adult Abuse Hotline 1 (800) 827-8724

CFS 125 CPS (1/13)

Distribution: Original - Case Record
Copy - Caretaker