HEALTHWORKS of Illinois – HEALTH SERVICES ENCOUNTER FORM

Please use 1 form for each child – Please see instructions on the reverse side

PLEASE PRINT!

Child's Name (Last, First, MI):	Sex:	Age:	D.O.B.:
Ethnicity:	Language Spoken:	Patient Social Security # (if known):	
Mother's Name:	Mother's Phone #:		
Current or Planned Placement Street Address:		Apt. #:	
City:	St.:	Zip Code:	Placement Location Phone #:
Placement Type:	Name of Adult Contact at Placement Location:		

Exam Date:	Time IN: AM / PM	Time OUT AM / PM	Exam Type:	Initial Health Screening		# of Children in Group
				Comprehensive Eval.		
Name of Adult Escorting Child to Exam						Case worker
						Care Taker
Who gave consent for examination/treatment:		Phone #:				Supervisor
						Parent/Guardian

Current Case Worker Name:	Case Worker ID #:
Telephone #:	Region/Site Field:
DCFS Child Case #:	Prot. Custody Date: / Prot. Custody Time:
Temp. IDPA Medical Card Serial #:	Date Temporary Custody Awarded:
Child's IDPA Recipient #:	
Child's IDPA Case: 9|8	
Previous Health Provider:	Phone #:

Provider Site Name:		
Provider Street Address:		
City:	St.:	Zip Code:
Provider Phone #:		

*Caseworker or Adult Escorting Child must complete the **TOP** portion of this form. Medical Provider completes **BOTTOM** portion of form.*

Health Problems Identified / Suspected per Initial Health Screening:

Mental Health Status:

Substance Abuse:

Physical Abuse:

Sexual Abuse:

Immunization History:

Communicable Diseases:

Other Health Problems:

Current Prescribed Medications: Rx:
(Include medications prescribed today and previous, if known)

Immunizations / Treatments Given Today:

Follow-up Care & Evaluations Required / Recommended:

	W/in 24 Hrs.	W/in 72 Hrs.	Primary Care MD

☐ Lab/Test Results Pending - Please call — Phone #:

Referral for follow-up medical care made to: — Phone #:

PHYSICIAN: Please Indicate Placement Recommendation

- ☐ No Medical Restrictions on Placement
- ☐ Hospitalization Required – Admit to _____ Hospital
- ☐ Ongoing Supervision By Health Professional Required – see plan above.
- ☐ Communicable Disease / Conditions:
- ☐ Behavioral Concerns-Please Explain:
- ☐ Other-Please Explain:

EXAM TYPE/Health Passport Status/Physician Signature

Exam Type: ☐ Initial Health Screening ☐ Comprehensive Eval # of Children in Group _____	Examining Physician's Name PLEASE PRINT!!	Examining Physician's Signature/Date:	Time:
Was Child's Health Passport: / Initiated @ comp ?			
If not, please indicate why			

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WHITE COPY: HEALTHWORKS • YELLOW COPY: Retain with Health Passport • PINK COPY: DCFS • GOLD COPY: Provider Records