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

Health Summary Form – Well-Visit

Well-Visit for Infants/Children/Youth in DSS Custody*

Instructions: Provider completes this form at each well visit or provides a summary containing the requested information.

Copy given to_____ (caregiver) on____/____/_____by_____

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

Patient's Medicaid ID Number: _____

Physical Examination: ATTACH 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-SE, ECSA, PHQ-9, Vanderbilt, SCARED)
No Concerns_____ **At Risk/Concerns**_____

Current health conditions/issues (acute/chronic):

_____

_____

_____

Medications provided/prescribed:

_____

_____

_____

Other concerns (home, school, community):_____

_____

_____

Immunizations (administered this visit):

_____

_____

_____

Allergies:

_____

_____

_____

Health Summary Form – Well-Visit

Referrals (specialty care/CC4C/home visits): **Addressing what need:**

_____ _____

_____ _____

_____ _____

PSYCHOTROPIC MEDICATION REVIEW REQUESTED: ☐ YES ☐ NO

Treatment plan (follow-up appointment/labs/testing/needed immunizations):

_____

_____

Comments or instructions for DSS/caregivers/school personnel:

_____

_____

Next Well-Visit date/time: _____

Provider name: _____

Provider signature: _____

(stamp)

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

DATE: **INITIALS:**

*Adapted from AAP's Healthy Foster Care America Health Summary Form