

TREATMENT FOSTER CARE HEALTHCARE APPOINTMENT RECORD

UMCH Treatment Foster Care Program
526 N. Cassingham Road, Columbus, OH 43209
(614) 559-2800 • (614) 559-2801 (fax)
www.umchohio.org

Youth: _____

DOB: _____

Social Security Number: _____

Medicaid/Insurance #: _____

Healthcare Provider:

Name

Street Address

City, State, Zip Code

Date of Service: _____

Time: _____

Reason For Visit:

Physical (*Hearing Evaluation & Lead Screening)

Dental

Vision

Other (Explain) _____

Procedures Performed: _____

Diagnosis: _____

Recommendations: _____

Height: _____
Weight: _____

Medication Prescribed	Dose	Frequency/Duration	Purpose for Medication

For Questions: Contact Name: _____

Phone Number: _____

Signature of Authorized Medical Personnel

Date

Please complete this form and return to patient.

NOTE: **Medical** - Physical within 14 Days and then Annually

Dental – Visit within 30 days and then every 6 months

Vision – Visit within 30 Days and then Annually/Bi-Annually

* One time assessments: Lead Screening

Auditory

are due within 14 days of placement

Copies: UMCH Case Record

Caseworker

UMCH Foster Parent

Revised 03/24/06

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