



STATE OF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES
Medical Questionnaire/Request for Information



To:	HEALTH CARE PROVIDER	DATE
	ADDRESS	FAX

From:	DCF INVESTIGATOR	TELEPHONE
	AREA OFFICE	FAX

The Department of Children and Families has an open investigation concerning the child listed below. In accordance with our investigation policies, we are requesting information that would become part of the confidential file. Enclosed is a signed authorization to release information for your records. We ask that you take a moment to complete this form and return it to us **within two weeks**. Thank you for your anticipated assistance in this matter.

Family or Custodial Parent's Name:			
Child/Youth:		DOB:	
Date of Last Physical:		HT:	WT: BMI:
How long has the child been a patient in your practice? _____ years			
Has child been seen elsewhere for medical care? If so, where?		NAME OF PROVIDER:	
Is the patient up to date with immunizations and well child visits?	<input type="checkbox"/> YES	IF NO, WHAT IS NEEDED?	
	<input type="checkbox"/> NO		
Has child had lead level checked?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE:	LEVEL:
Are there any identified medical or dental problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE EXPLAIN:	
Are there any developmental, behavioral, or mental health concerns?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE EXPLAIN CONCERN AND ANY SPECIALIST REFERRALS MADE:	
If the patient is less than three (3) years of age would this patient benefit from a referral of Birth to Three Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, was a referral made to Birth to Three ? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Check here if patient already involved with Birth to Three	

Is the child presently on any medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST MEDICATION AND WHAT IT IS PRESCRIBED FOR:	
List any specialist referrals made and dates:	NAME OF SPECIALIST:		DATE OF REFERRAL:
Any missed appointments/ pattern of missed appointments or other concerns you would like to discuss with the DCF investigator?			

Health Care Provider's Signature:		Date:	
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<input type="checkbox"/> Need to speak with Social Worker	BEST DAYS AND TIMES TO CONTACT:	
	Days:	_____
	Times:	_____
	Telephone:	_____

Please attach a copy of: Immunization records
 Last physical exam

Fax to:
Fax #

PLEASE RETURN WITHIN TWO WEEKS