STATE OF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES
505 Hudson Street • Hartford, CT 06106

REPORT OF HEALTH CARE VISIT

Please Complete for Any Health Care Visit

Date of Visit:		Type of Visit (check one):	☐ Medical ☐ Dental ☐ Mental Health	☐ Well Child Exam ☐ Sick Visit ☐ Follow-Up Visit	☐ Other (specify):

Social Worker	NAME	TELEPHONE
	AREA OFFICE	FAX

Child	NAME				
	DATE OF BIRTH	AGE	PRIMARY LANGUAGE	CASE ID #	CHILD ID #

PROVIDER

Growth	HT: _____ (_____%) WT: _____ (_____%) BMI: _____ (_____%) HC: _____ (_____%)		
Diagnosis			
Lab Work/Tests Ordered?	☐ YES ☐ NO	IF YES, PLEASE EXPLAIN	
Immunizations Given?	☐ YES ☐ NO	IF YES, PLEASE LIST	**Please attach copy of completed immunization record**
Findings/ Comments:			
Recommendations/ Treatment/ Medication			
Referral to Specialist?	☐ YES ☐ NO	IF YES, PLEASE INDICATE NAME OF SPECIALIST AND REASON FOR REFERRAL	
Follow-Up Needed?	☐ YES ☐ NO	Next Appointment:	

Provider	NAME	
	ADDRESS	FAX

☐ **Need to speak with Social Worker**

BEST METHOD FOR CONTACT:

Time: _____

Telephone: _____

WHITE – to Caretaker / YELLOW – to Case Record / BLUE – to Provider