Utah DCFS
Form 984

HEALTH VISIT REPORT

DCFS Legal Medical Document—Fill Out Complete & Legible—Return to DCFS/FHC Within 3 Days Of Visit

RETURN COMPLETED FORM OR COMPLETED CLINIC NOTE & MED LIST TO DCFS/FHC—FAX # 801-536-0493

BASIC INFORMATION

Child's Name:_____ **DOB:**_____ **Current Age:**_____

Visit Date:_____ **Medicaid ID:**_____ **Caseworker:**_____

Attending Visit: ☐ Parent ☐ Foster Parent ☐ Tracker ☐ Other:_____

Provider Type: ☐ Medical ☐ Dental/Orthodontic ☐ Mental Health/Therapy

PRACTITIONER FINDINGS

VISIT TYPE: ☐ Well Child Check ☐ Sick/PRN ☐ Dental/Orthodontic ☐ Mental Health/Therapy ☐ Med Manage ☐ (Include Oral exam < age 3 on WCC)

CHIEF COMPLAINT/VISIT REASON:

T._____ **BP.**_____/_____ **P.**_____ **RR.**_____ **O2%.**_____

Ht._____/_____% **Wt.**_____/_____% **BMI.**_____/_____% **OFC.**_____/_____%

PRN SCREEN: VISION: OD 20/_____ **OS** 20/_____ **OU** 20/_____ **HEARING: AD**_____ **AS**_____ **AU**_____

DIAGNOSIS/ABNORMAL EXAM FINDINGS: (Include duration/severity)

LAB TESTS/DIAGNOSTICS: (List or attach results if known)

TREATMENT PROVIDED/PLAN: (List medication changes in box below)

FOLLOW UP/REFERRALS:

IMMUNIZATIONS GIVEN:

☐ Hep A ☐ Hep B ☐ MMR ☐ Varicella ☐ T Dap ☐ D Tap ☐ Td ☐ HPV ☐ Meningitis ☐ Pneumonia
☐ Polio ☐ HIB ☐ Flu ☐ Rotavirus ☐ Other:_____

Complete ALL Sections **MEDICATION CHANGES THIS VISIT** **(N=New C=Change D=Discontinue)**

ALLERGIES: ☐ NKMA ☐ PCN ☐ Sulfa ☐ Other:_____

MEDICATION:	DIAGNOSIS/CONDITION:	DOSE:	ROUTE:	FREQ:	DURATION:	STATUS:
						N C D
						N C D
						N C D
						N C D
						N C D

Provider Printed Name:_____ **Phone#:**_____

Provider Signature:_____ **Date:**_____

Provider Office/Location:_____ **NPI#:**_____

Original Copy: COMPLETE & return to DCFS/FHC within 3 days of visit **Duplicate Copy**: Keep with child/caregiver in home binder

Template Revision: Nov 2019