

**Patient Information**

--	--	--

**Child's Name**

**Date of Birth**

**Date of Physical Exam**

Is child up-to-date on all well child care?  Yes  No

If NO, please explain what is needed: \_\_\_\_\_

This practice is the child's medical home?  Yes  No

Is child a WIC Participant? (FAX referral to 734-544-6725)  Yes  No

**\*\*\* ALL INFORMATION BELOW IS REQUIRED ANNUALLY AND MUST LIST DATE OF TEST WITH RESULTS \*\*\***

TYPE	DATE	RESULTS	NORMAL	REFERRED	UNDER CARE
Height					
Weight					
Blood Pressure					
Vision Screening					
Hearing Screening					
Hematocrit/Hemoglobin					
Lead*					

\*Blood Lead Levels are required for all children enrolled in Medicaid & Head Start and must be tested at 1 and 2 years of age, or once between 3 - 6 years of age if not previously tested at both 1 and 2 years of age. All children under age 6 considered "high-risk" (on Medicaid and/or enrolled in Head Start) need a blood lead test completed at 3 years of age per Federal Head Start requirements (or at 4 years of age if not completed at 3 years).

<b>Oral Health Screening</b>		Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home.
------------------------------	--	--

**Special Conditions or Considerations**

If any screenings are failed or abnormal, please describe treatment plan or follow-up recommendations:

**Critical Medical Conditions**

Please list any medical conditions (including asthma, food allergy, seizures, nutritional concerns, abnormal findings and disabilities that can be supported by our program):

**Health Provider Contact Information and Signature**

Print Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

**Provider Signature**

**Date of Signature**

