DENTAL EXAMINATION FORM - INSTRUCTIONS

MEDICAL RECORD PROCEDURES FOR FOSTER CAREGIVERS (Caregiver is a Foster Parent, Relative, Group Home, or FFA.)

The HEALTH & EDUCATION PASSPORT (HEP) BINDER accompanies each child at the time of placement. The Children's Social Worker (CSW) will review the HEP BINDER with you at each visit.

The Health and Education Passport must be taken to all medical visits, including the initial examination visit. The health care provider must record all current medical services and tests on the DCFS 561(b). Please add the completed forms to the child's HEP BINDER.

Immediately notify the child's CSW (or Supervising CSW, if the CSW is unavailable) when there is any change in the child's mental, medical and/or dental health that required urgent medical care.

If the child is removed from your care, the child's complete HEP BINDER, including the Immunization Record, shall be returned to the CSW *at the time of removal*, as the HEP BINDER must accompany the child upon replacement.

Dental Care Examination Periodicity Schedule: Annual dental examination required at age 3 and above.

(To be completed by CSW/Caregiver. Please print legibly.)

☐ Child needs dental examination within thirty (30) days of initial placement.
☐ Child does not need dental examination because child had a dental examination within one (1) year of placement.
☐ Child needs dental examination by _____.

CHILD's NAME: _____ DOB: _____ CASE #: _____ DATE PLACED: _____

CAREGIVER: _____ (Phone) _____ (FFA) _____ (Phone) _____

CSW: _____ (File #) _____ (Phone) _____ (Fax) _____

Dental data entered into CWS/CMS by: (Name) _____ (Date) _____

DENTAL EXAMINATION FORM (To be completed by Dentist.)

DENTAL EXAMINATION

Date of Dental Examination: _____ Name of Dentist: _____

☐ Annual Required Examination
☐ Other/Follow-Up Visit
☐ Dentist's own exam form is attached. If not attached, complete below.

Dental Exam results: (Treatment given; Medications Prescribed. Please attach copies of supporting documentation; test results, etc.)

_____

_____

_____

(May be continued on additional pages if necessary. If so, provider to include child's name and DOB, and sign and date additional pages.)

If follow-up care indicated, specify: _____

Signature of Health Care Provider: _____(Date)_____
(Dentist)

Address: _____ Phone: _____

(Signature Stamp Required)

Distribution: Pages 1, 2 and 3 to foster caregiver when child initially placed.
Page 4 to be filed in Psychological/Medical/Dental folder (purple).
When page 1 returned, file in Psychological/Medical/Dental folder.