Utah DCFS
Form 984

HEALTH VISIT REPORT

Reset Form

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

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: April 2018