**Placement Services**

**221 Penn Avenue**

**Wilkinsburg, PA 15221**

**Phone #: 412-342-2300**

**Fax #: 412-247-6399**

**MEDICAL RECORD INFORMATION**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_ Date of Appointment:\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Routine/well child:  EPSDT: Follow-up Care  Rationale:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Circum.:\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ Height: \_\_\_\_\_Temp:\_\_\_\_\_ Pulse:\_\_\_\_\_ BP: \_\_\_\_\_ BMI: \_\_\_\_\_\_\_

List immunizations provided at today’s appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note any area of medical problems in the following:

|  |  |  |
| --- | --- | --- |
| **PHYSICAL EXAMINATION** | **√ = NORMAL** | **NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL** |
| Head |  |  |
| Ears |  |  |
| Eyes |  |  |
| Nose |  |  |
| Throat |  |  |
| Teeth |  |  |
| Cardiorespiratory |  |  |
| Abdomen |  |  |
| Genitalia/Breast |  |  |
| Extremities/Joint/Back/Chest |  |  |
| Skin/Lymph Nodes |  |  |
| Neurological/Developmental |  |  |

|  |  |  |
| --- | --- | --- |
| **SCREENING TESTS** | **DATE TEST DONE** | **NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL** |
| Vision |  |  |
| Professional Dental Exam |  |  |
| Hearing:  Right \_\_\_\_\_Left\_\_\_\_\_ |  |  |
| Communicable Disease |  |  |
| Blood Work |  |  |
| Urinalysis |  |  |
| Sickle Cell |  |  |

Health problems or special needs. Recommended treatment/medications/special care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 None

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Revised: 10/13/2009dn, 11/7/14 amg**