Mandated:

Physical ____Y____N
Dental ____Y____N
Eye ____Y____N

# MEDICAL SERVICE REPORT

(pursuant to ODJFS Rules 5101: 2-42-661 and 662)

Department of Children and Family Services
Health Care Unit, Rm 119 E
3955 Euclid Avenue, Cleveland, OH 44115-2505
Phone: (216) 881-4712
Fax: (216) 431-4109
After hours Authorizations: (216) 696-KIDS
Medicaid Hotline: (216) 432-3389

**Child's Name:** **DOB:** **CFS Person ID:**

**CFS Social Worker** **CFS Supervisor** **CFS Chief F**

**Billing Number:**

**Social Security #** **Medical Record #** **Date of Visit**

**Services Provided: (Please place a ✔ in the appropriate boxes)**

- ❑ Triage/Contagious Disease/Abuse Pre-Placement Screening
- ❑ Comprehensive Physical Examination (HealthChek)
- ❑ Dental Exam/Treatment
- ❑ Vision Exam/Treatment
- ❑ Hearing Exam/Treatment
- ❑ Routine/Well Child Visit
- ❑ Sick Visit/Follow-up Sick Visit
- ❑ Specialist Consultation/Visit
- ❑ Acute Care/Subspeciality Exam/Treatment
- ❑ Medication Assessment / Follow-up
- ❑ Emergency Room Treatment / Urgent Care
- ❑ Hospitalization - Medical / Surgical
- ❑ Other, please specify _____

Next Appointment Date

**Diagnosis:** _____

**Treatment Provided:** _____

**Rx Ordered:** _____

**Please ✔ any Immunizations(s)** ***Given TODAY only***

| | | | | |
|---|---|---|---|---|
| ❑ OPV #1 | ❑ DPT #1 | ❑ MMR #1 | ❑ Hep B-1 | ❑ Hib #1 |
| ❑ OPV #2 | ❑ DPT #2 | ❑ MMR #2 | ❑ Heb B-2 | ❑ Hib #2 |
| ❑ OPV #3 | ❑ DPT #3DTaP | ❑ MMR #3 | ❑ Hep B-3 | ❑ Hib #3 |
| ❑ OPV #4 | ❑ DPT #4/DTaP | ❑ Varicella #1 | ❑ Hep B (catch-up) | ❑ Hib #4 |
| ❑ Td | ❑ DPT #5/DTaP | ❑ Varicella (catch-up) | ❑ Other | |

**Was the child referred to another Provider/Specialist/Assessment?** ❑ No ❑ Yes

**Name of Provider/Speciality/Assessment:** _____

***Would you like the CFS Social Worker to call you concerning this child?*** ❑ *Yes* ❑ *No*

***Regarding:*** _____

Please STAMP, TYPE or PRINT Medical Provider's Name, Address, and Phone Number including Area Code.

Medical Provider's SIGNATURE