

**MEDICAL TREATMENT**

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| TO THE DOCTOR:TO ENABLE US TO KEEP UP-TO-DATE WITH THE MEDICAL PROGRESS OF OUR CHILDREN/YOUTH IN ALTERNATIVE CARE, WE WOULD ASK YOU TO COMPLETE THIS FORM EACH TIME YOU EXAMINE OR TREAT A CHILD IN ALTERNATIVE CARE, (ASIDE FROM FULL ANNUAL MEDICAL EXAMINATIONS) WHETHER AT HOME, IN YOUR OFFICE, OR AT HOSPITAL.PURPOSE FOR THIS EXAMINATION: (TO BE FILLED IN BY AN ALTERNATIVE CAREGIVER, SOCIAL WORKER, OR CHILD/YOUTH) |
| CHILD’S NAME | DATE OF BIRTH |
| DATE OF EXAMINATION | HEALTH CARD NUMBER | FILE NUMBER |
| WORKER’S NAME | TELEPHONE NUMBER |
| Accompanying Person to the Medical Visit | TELEPHONE NUMBER |
| ALTERNATIVE CAREGIVER’S NAME | TELEPHONE NUMBER |

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| **TO BE COMPLETED BY THE DOCTOR**PROVISIONAL DIAGNOSIS: Click or tap here to enter text.TREATMENT PRESCRIBED: Click or tap here to enter text.DOCTOR’S INSTRUCTIONS TO THE: ASSIGNED WORKER ALTERNATIVE CAREGIVER  CALL ME TO DISCUSS THIS REPORT: YES [ ]  NO [ ]  |
| DOCTOR’S NAME (PLEASE PRINT) | DOCTOR’S SIGNATUREDATE: Click or tap to enter a date. |
| MAILING ADDRESS *(OFFICE STAMP ACCEPTABLE)* |
| TELEPHONE NUMBER |

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