RIVERSIDE COUNTY DEPARTMENT OF PUBLIC SOCIAL SERVICES
REPORT OF MEDICAL EXAM

FOR HEALTH PASSPORT UPDATE
RETURN IN THE POSTPAID ENVELOPE

CHILD:
CASE #:
DOB:
WORKER NAME:

TO BE COMPLETED BY THE MEDICAL PROVIDER: ICD-9 (IF EASILY AVAILABLE)

Date of Visit:

Results of exam and/or Diagnosis given:

Treatment given:

Immunizations Given Today:

☐ IPV #1 ☐ DTP/DT/DTaP#1 ☐ HIB#1 ☐ MMR#1
☐ IPV #2 ☐ DTP/DT/DTaP#2 ☐ HIB#2 ☐ MMR#2
☐ IPV #3 ☐ DTP/DT/DTaP#3 ☐ HIB#3 ☐ Varicella #1
☐ IPV #4 ☐ DTP/DT/DTaP#4 ☐ HIB#4 ☐ Varicella #2
☐ DTP/DT/DTaP#5
☐ HEP A#1 ☐ HEP B #1 ☐ Pneumococcal
☐ HEP A#2 ☐ HEP B #2 ☐ Rotavirus
☐ HEP B #3 ☐ Influenza
☐ Tdap ☐ HPV ☐ Meningococcal

Other Immunizations:______________________

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Results of tests done today

HEIGHT (in.)__________ HEARING __________
WEIGHT (lbs)__________ VISION __________

☐ TB TEST Date given________Date read ______
RESULTS mm ______ ☐ NEG ☐ POS
(If positive x-ray results) ______________

☐ HGB/HCT __________
☐ LEAD SCREEN: ________

OTHER TESTS: ______________

TYPE OF VISIT: ☐ ROUTINE COMPREHENSIVE (WELL CHILD)
☐ FOLLOW-UP

☐ Tx ONGOING ☐ Tx COMPLETED ☐ MEDICATIONS PRESCRIBED ____________
☐ SICK VISIT ☐ SPECIALIST VISIT ______________________
☐ WIC VISIT ☐ MEDICATION CHECK ______________________

WAS CHILD REFERRED TO ANOTHER PROVIDER? ☐ NO ☐ YES (If Yes, please complete)

NAME:______________________ SPECIALTY: ______________

ADDRESS: ______________________ TO BE SEEN WHAT DATE: ____________

TELEPHONE: ( ) ______________

PLEASE FILL OUT OR ATTACH BUSINESS CARD:

PHYSICIAN'S NAME: ______________________
ADDRESS: ______________________
CITY/STATE: ______________________
TELEPHONE: ( ) ______________________

RETURN TO: KRISTEN THOMPSON, PUBLIC HEALTH NURSE
DPSS CHILDREN'S SERVICES
11070 MAGNOLIA AVE. STE A
RIVERSIDE, CA 92505
PH: (951) 358-5667 FAX: (951) 358-5414