north star
family center

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HEALTH CARE VISIT FORM

Health Care Provider: Please complete for any health care visits

TYPE OF VISIT (Check one): ☐ Medical ☐ Dental ☐ Mental Health ☐ Vision

PURPOSE OF VISIT (Check One): ☐ Sick Visit ☐ Routine Dental ☐ Follow-Up ☐ Specialist Visit

☐ **Referral made to:** _____

Name:		**Date of Visit:**	**DOB:**
Growth:	**HT:**	**WT:**	**HC:**
Diagnosis:			
Treatment/Medication:			
Immunization Given:		☐ **TB Skin Test** **Results: (+)** ☐ **(-)** ☐	
Tests:			

Vision: _____/_____ ☐ **Normal** ☐ **Abnormal** **Note:** _____	**Hearing:** **RT:** ☐ **Normal** ☐ **Abnormal** **LT:** ☐ **Normal** ☐ **Abnormal** **Note:** _____	**Blood Lab:** **Hgb:** _____ **Lead Level:** _____ **Note:** _____

Additional Comments:

Provider Name: _____ **Provider Signature:** _____

Address: _____ **Telephone/Fax No.:** _____

Not to Replace CHPD/Physician Report Forms