



### HEALTH TREATMENT REPORT

The Department of Health and Human Services requires medical practitioners provide foster care agencies with documentation for all appointments for medical and dental related treatment other than routine counseling.

Client's Name: \_\_\_\_\_  
Client ID #: \_\_\_\_\_  
Date of Treatment/Appointment: \_\_\_\_\_  
Practitioner's Name: \_\_\_\_\_  
Practitioner's Address: \_\_\_\_\_  
Practitioner's Phone #: \_\_\_\_\_

REASON FOR TREATMENT/APPOINTMENT: (please check one)

- |  |   |
|--|---|
| <input type="checkbox"/> Medical Annual Physical | <input type="checkbox"/> Dental Biannual Exam   |
| <input type="checkbox"/> Medical Other (specify) | <input type="checkbox"/> Dental Other (specify) |
| <input type="checkbox"/> Medication Review       | <input type="checkbox"/> Eye Care/Examination   |

RESULTS OF TREATMENT/APPOINTMENT:

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

IS FOLLOW UP NEEDED? PLEASE EXPLAIN:

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

MEDICATION(S) PRESCRIBED (if psychotropic medications prescribed complete behavioral section):

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

BEHAVIORAL INTERVENTIONS TO REDUCE RELIANCE ON PSYCHOTOPIC MEDICATION:

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

OVER THE COUNTER MEDICATION(S) THAT MAY HAVE AN INTERACTION WITH THE MEDICATION(S) PRESCRIBED:

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

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

Please complete this form in blue or black ink.

SEC08-002-021307

**CONFIDENTIAL**