TULARE COUNTY HEALTH AND HUMAN SERVICES AGENCY
HEALTH CARE ENCOUNTER FORM

Health Care Provider: Please complete for any health care visit.

Date of Visit: __/__/__ Name: D.O.B.

Growth:	**Ht:**	**Wt:**	**HC:**
Diagnosis:			
Treatment/ Medication:			
Immunization Given:			
Tests:			
Additional Comments:	☐ **Hgb:**_____ ☐ **Lead Level:**_____ **VISION:** ☐ **Normal** ☐ **Abnormal** **Hearing:** ☐ **Normal** ☐ **Abnormal** **Other:**		

TYPE OF VISIT (Check one): [ ] Medical [ ] Dental [ ] Mental Health
PURPOSE OF VISIT (Check one): [ ] Routine CHDP Exam [ ] Routine Dental Exam

[ ] Sick Visit [ ] Follow-Up [ ] Specialist Visit

[ ] Referral Made to:_____
Currently Receiving Services From: [ ] Children's Services [ ] Regional Center [ ] Other

Signature of
Provider: _____**Telephone:**_____

Name of Provider:_____ **Fax No:**_____

Please return form to Family Builders Foster Care, Inc