ENCOUNTER FORM

Name of Child:		**DOB:**	**Date:**	
Medical	**Dental**	**Behavioral Health**	**Vision**	**Hearing**
☐ 7 day Medical Screening	☐ Oral Exam/Cleaning	☐ Psych Evaluation	☐ Evaluation	☐ Evaluation
☐ 30 day Comprehensive Exam	☐ Follow-Up (*Describe below.)*	☐ Follow-Up (*Describe below*.)	☐ Follow-Up (*Describe below*.)	☐ Follow-Up (*Describe below*.)
☐ Emergency Room Visit	☐ Orthodontia (Braces)	☐ Medication		
☐ Sick Visit	☐ Surgery	☐ Crisis Evaluation		
☐ Well Child Visit				
☐ Immunization				
☐ Follow-up (*Describe below*)				
☐ Surgery				

Diagnoses/Conditions (medical, mental health, developmental, learning and substance use) :		
Procedures done and results, if available:		
Immunizations given:		
Allergies:		
Prescription(s) given:		

Is follow-up or referral to another provider needed? ☐ Yes ☐ No *(If yes, describe below.)*

Other important medical and social information (if applicable):

Provider Signature:	**Provider Name** *(Print.)***:**
Facility:	**Telephone Number:**

AGENCY USE ONLY: Date entered in FamilyNet *(File copy of Encounter Form in Medical section of paper case record.)*

Rev.January, 2010