

# UMATILLA-MORROW HEAD START - HEALTH REFERRAL & FOLLOW-UP RECORD

**CHILD'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **CENTER:** \_\_\_\_\_

**REFERRED TO:**      9FA/CFA                      9MENTAL HEALTH                      9NUTRITION                      9TEAM LEADER  
                                  9HRS                                      9EDUCATION/DISABILITIES                      9FAMILY DEVELOPMENT                      9OTHER: \_\_\_\_\_

**REFERRAL COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FOLLOW UP PLAN:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HSD SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CHILD PLUS DATA ENTRY:**

SERVICE	PROVIDER	STATUS	RESULTS	FUNDING	TREATMENT PLAN
DEVEL. HX					
HLTH HX					
VISION					
HEARING					
PE					
TB					
BP					
HGB/HCT					
HT/WT					
NUTRITION					
DENTAL					

Screening Codes: A-Absent/No Show, U-Un-testable/CNT, P-Passed, N-Failed First Screen/Needs Re-screen, F-Failed Screening/Follow-up Required  
 G-Failed 3<sup>rd</sup> Screening/Follow-up Required, B-Service Refused by Parent, I-More Information Needed.

**RETURN COMPLETED FORM TO HEALTH SERVICES DIRECTOR WITH FOLLOW UP DOCUMENTATION ATTACHED**

**FOLLOW-UP REPORT:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9 Parent declines the following services: \_\_\_\_\_

Explain why services are being refused: \_\_\_\_\_

**PARENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CFA/FA, HRS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**HSD COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HSD SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CHILD PLUS DATA ENTRY:**

SERVICE	DATE	TX STATUS	PROVIDER	FUNDING	TREATMENT PLAN: REVISION

Treatment Codes: E-Evaluation Complete, T-Treatment Complete, I-In Progress, R-Referred, C-Treatment Up-to-Date/Not Complete, P-Parent Refuses Treatment/Follow-up.