COLORADO
Department of Public Health & Environment

HCP Specialty Clinic Visit Record

HCP for Children and Youth with Special Health Care Needs

Clinic Date _____ Pediatric Specialist _____

Clinic Location _____ Clinic Type ☐ Neuro ☐ Rehab ☐ Ortho

Child/Youth's First Name _____ Child/Youth's Last Name _____

DOB _____ Age _____ ☐ Male ☐ Female Insurance _____ Ins. ID _____

Parent Name _____ ☐ Guardian

Mailing Address _____ E-mail _____

City _____ Zip _____ County _____ Phone Number _____

PCP Name _____ PCP Phone _____ PCP Fax _____

PCP Address _____ PCP City _____ PCP Zip _____

Medical Conditions:

☐ New Diagnosis

Medication	Frequency/Doses	Notes

Allergies:

Immunization Status: ☐ Up to Date ☐ Needed

Vital Signs: HR: _____ RR: _____ BP: _____

Wt: _____ %tile: _____ BMI _____

Head Circumference: _____ %tile: _____

Ht: _____ %tile: _____

Plotted: ☐ Yes ☐ No

Concerns / Assessment / Plan / Follow-up (include persons responsible & use back of form if needed):

☐ Lab ☐ X=Ray ☐ EKG/EEG ☐ Consult ☐ Medication Changes ☐ Refer to Care Coordination ☐ Other

Schedule Next HCP Specialty Clinic Visit in _____ ☐ Follow-up with PCP

Completed By: _____ Title _____

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