RECORD OF MEDICAL TREATMENT

State Form 45092 (R3 / 9-05) / CW 3320

The information contained on this form is **CONFIDENTIAL** according to IC 31-34 / IC 31-37 / 42 USC 622.

Name of child	Date of birth *(month, day, year)*	Case number
Name of foster parent	Date of treatment *(month, day, year)*	Medicaid / Insurance policy number
Name of local DCS office		
Address of local DCS office *(street, city, state and ZIP code)*		
Name of family case manager		Telephone number of family case manager ( )

PRESENTING PROBLEM

OBSERVATIONS

TREATMENT

GENERAL COMMENTS

RECOMMENDATIONS FOR FUTURE HEALTH CARE AND FOLLOW-UP TREATMENT

Signature of provider	Date signed *(month, day, year)*

DISTRIBUTION: White - **Provider;** Canary - **local DCS office;** Pink - **Foster parent**