**CHILDREN’S SPECIAL HEALTH SERVICES FLOW SHEET**

1. **Last Name**
   - [ ]
2. **First Name**
   - [ ]
3. **MI**
   - [ ]
4. **Patient Number**
   - [ ]
5. **Date of Birth**
   - [ ]
6. **Race**
   - 1. White
   - 2. Black/African American
   - 3. American Indian/Alaska Native
   - 4. Asian
   - 5. Native Hawaiian/Other Pacific Islander
   - 6. Other
7. **Ethnicity:**
   - [ ] Hispanic/Latino Origin
8. **Gender**
   - 1. Male
   - 2. Female
9. **County of Residence**
   - [ ]
10. **CLINIC TYPE**
    - [ ] Cardiology
    - [ ] Myelomeningocele
    - [ ] Neurology
    - [ ] Neuromuscular
    - [ ] Orthopedic
11. **ALLERGIES** (food, drugs, insects, environmental)
12. **English Speaking**
    - 1. Yes
    - 2. No
13. **Interpreter?**
    - 1. Yes
    - 2. No
14. **Informant/Relationship**
15. **Current Problem; Complaint; or Parental Concerns**
    - (Update at each visit)
    - ♦ Date & Age of Onset (Update as needed)
    - ♦ Course & Duration (Update as needed)
    - ♦ Effect of Treatment, if applicable (Update as needed)
    - ♦ Referral Source (Update as needed)
16. **Immunization Status; Referral/Follow – Up**
17. **Current Provider for Well Child Care/Medical Home**
    - ♦ Date of Last Well Child Visit
18. **Other Medical or Health Care Problems/Providers**
19. **Current Medications:**
    - Prescribed/ Over The Counter
20. **Therapies:**
    - Speech, OT, PT, Nutrition, CSC,
    - Early Intervention, Special Education
21. **Durable Medical Equipment:**
    - Type/Need/Repair
22. **Signature**
23. **Education/Counseling Provided for Each Diagnosis and Treatment**
    - ♦ Clinical Findings Including Diagnosis
    - ♦ Treatment: Medication/Diagnostic Tests/Casting
    - ♦ Special Therapy/Durable Medical Equipment
24. **Signature**
CHILDREN’S SPECIAL HEALTH SERVICES FLOW SHEET (DHHS 2809)

This flow sheet is designed to monitor children with special needs through adolescence. Health problems which cannot be documented adequately with the code abbreviations require a SOAP or Narrative note on the Notes (DHHS 2803). Record the letter “N” from the code in the appropriate box on the Children’s Special Health Services Flow Sheet to reference information in the Notes.

1.-6. NAME, NUMBER, ETC  
In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient’s identification card or manually record the patient’s name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YYYY), race and ethnicity, gender, and county of residence.

7. ENGLISH SPEAKING  
Check “Yes” or “No” as appropriate. If “No”, record the language spoken.

8. INTERPRETER  
Check “Yes” or “No” as appropriate. If “Yes”, record who is providing interpretation.

9. ALLERGIES  
List all patient’s allergies: food, drugs, insects, environment. Record in red ink if possible.

10. CLINIC TYPE  
Check as appropriate.

11. DATE/AGE  
Enter the date of the assessment and age of the child at the time of the visit at the top of each successive column.

12. INFORMANT/RELATIONSHIP  
Record informant’s relationship to the patient. As appropriate, note if informant is not able to provide needed information.

13. CURRENT PROBLEM; COMPLAINT; PARENTAL CONCERNS  
Record reason for the visit, including complaints or parental concerns. Use informant’s words if possible. **Update at each visit.** Record the following information with updates as needed: Date and Age of Onset; Course and Duration; Effect of Treatment; and Referral Source.

14. IMMUNIZATION STATUS REFERRAL/FOLLOW-UP  
Record current status of immunizations. Indicate need for immunizations or follow-up to determine status.

15. CURRENT PROVIDER FOR WELL CHILD CARE/ MEDICAL HOME  
Record the name of the physician/health care provider/ medical home generally contacted. Record date of last well visit.

16. OTHER MEDICAL OR HEALTH CARE PROBLEMS/ PROVIDERS  
Identify and record other medical or health issues affecting this patient and providers as indicated.

17. CURRENT MEDICATIONS  
Record all over the counter or prescription drugs that patient takes on a regular basis.
18. SPECIAL THERAPIES
Record any speech, occupational, physical, nutrition therapies; Child Service Coordination, Early Intervention, Special Education this patient receives.

19. DURABLE MEDICAL EQUIPMENT
Record any special equipment the patient needs or uses on a regular basis and any repair needed for that equipment.

20. SIGNATURE
Record the full legal signature of the health professional responsible for the above information.

21. EDUCATION/COUNSELING PROVIDED
Record education/counseling provided for each diagnosis and treatment including clinical findings; treatments; and special therapies.

22. REFERRALS
Record by type or name, referrals to other health care providers, agencies, or immunizations.

23. DATE OF NEXT VISIT
Record the date given to the patient for the next scheduled visit.

24. SIGNATURE
Record the full legal signature of the health professional responsible for the information in items 20-22.