FLORIDA DEPARTMENT OF JUVENILE JUSTICE

SUMMARY OF OFF-SITE CARE CONSULTATION REPORT

Name of Youth: _____ DJJID#: _____

Facility Name: _____ Date of Service: _____

Allergies: _____ DOB#: _____

Insurance: _____ _____ _____

Company Name Contract # Group ID #

Youth Medicaid #: (if applicable) _____

Off-Site Health Care Facility Name: _____

Address of Health Care Facility: _____

Telephone Number: _____

Specialty Service being Provided: _____

REASON FOR REFERRAL

SUMMARY OF YOUTH'S MEDICAL CONDITION OR COMPLAINT.
(THIS SECTION TO BE COMPLETED BY FACILITY STAFF.)

_____

_____

_____

_____

_____

MEDICAL ASSESSMENT AND DIAGNOSIS

NOTE TO PROVIDER:

Please complete this summary of care and return the form with youth to facility. Please state any additional instructions for facility staff. Be aware that youth may reside at a facility, which does not have licensed health care staff on duty. This form is an official document of the youth's health care record. A copy of this document may be retained for your records.

_____

_____

_____

_____

_____

_____

Save As Reset/Clear Form Print Form

MEDICAL CARE AND TREATMENT

SUMMARY OF MEDICATIONS AND TREATMENTS ADMINISTERED

_____

_____

_____

_____

ORDERS

PLEASE ATTACH PRESCRIPTIONS TO FORM

NOTE TO PROVIDER:

This section is for orders such as prescriptions, treatments, activity restrictions, and special observation/precautions.

1. _____
2. _____
3. _____
4. _____

Comments:

_____

_____

_____

Were any diagnostic testing (lab, x-rays) done or ordered during this visit? ❑ Yes ❑ No

(Note: If lab values or x-ray results obtained please attach written reports with this summary.)

Please list any pending laboratory testing or x-ray results below:

Laboratory Results: _____ _____

Laboratory Name Telephone Number

Radiology reports: _____ _____

Diagnostic Center Name Telephone Number

Did youth receive any Immunizations during this visit? ❑ Yes ❑ No

(If yes please list and if applicable provide a date for next scheduled immunization):

_____

_____

Is a follow-up visit required: ❑ Yes ❑ No

If yes:

Health Provider Name: _____

Location: _____

Date: _____ Time: _____

_____ _____

Physician/Health Care Provider Signature Date