



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 (<i>month, day, year</i>)	Case number
Name of foster parent	Date of treatment (<i>month, day, year</i>)	Medicaid / Insurance policy number
Name of local DCS office		
Address of local DCS office (<i>street, city, state and ZIP code</i>)		
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 (<i>month, day, year</i>)
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