AU Number	
Case Head Name	
LDSS/District Office	
Fax Number	
Case Manager	
Case Manager Phone #	

Primary Prevention Initiative Health Care Form

Health Care Provider: please complete all appropriate sections of this form. Please sign and date it. You may return it to the patient or fax it to the case manager listed above.

Pre-school Children: birth through 6 years

Child's Full Name	**Child's Date of Birth**	**Child's Address**	**Date of Most Recent Exam**
Phone Number		**Fax Number**	

School Age Children: 7-18 years of age

Child's Full Name	**Child's Date of Birth**	**Child's Address**	**Date of Most Recent Exam**
Children's Health Care Provider's Name			
Facility Name			
Phone Number		**Fax Number**	

Adult's Full Name	**Adult's Address**	**Date of Most Recent Exam**
Adult's Health Care Provider's Name		
Facility Name		
Phone Number	**Fax Number**	

Were Family Planning Services discussed: Yes____ No____ Referral made for Family Planning Services _____

Health Care Provider Authorized Signature and Date: _____