Training Tip of the Week

FSFN Medical/Mental Health Record

The Florida Safe Families Network (FSFN) Medical/Mental Health Record details important medical information about a Child's current health care providers, basic health problems and histories (such as allergies, medications, and dietary concerns) and medical/mental health/dental and vision appointments.

The child's Medical/Mental Health Record is visible when looking at the Case Records on the FSFN Desktop. If one has been created and is not visible, uncheck the 'Date Restricted' box at the top of the desktop. Ensuring the information is entered timely, is accurate and complete is important. It feeds directly into the FSFN Case Plan and FSFN Judicial Review Social Study Report.

This Record consists of four tabs:

- The Medical Profile tab provides information about medical, dental or mental health providers involved with the child. Case Managers must enter all providers the child has on this tab (doctor, dental, therapist, eye doctor, specialist, etc.). This page also captures whether there are health concerns, allergies and the child's current immunization dates. Immunizations must be kept current per the CDC Immunization Schedule https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

- The Medications tab provides information on medications, whether over the counter or prescribed. Psychotropic drug information, prescribing physician, and any issues relating to the prescriptions are detailed here. If the child takes a daily multi-vitamin or supplement it also should be entered in. Over the counter vitamins or supplements can cause allergic reactions. You may need to research a drug if it does not appear in the drop down list, as new brand-name drugs and generic drugs are continually manufactured. If the name of the medication does not appear in the list, choose other and insert the name of the medication.

- The Mental Health Profile tab provides important mental health information about a Child's current mental health treatment and transition information. Information about the Comprehensive Behavioral Health Assessment date and findings is captured on this tab. The mental health history is also detailed in this tab.

- The Medical History tab must provide information on every medical, mental health, eye and dental appointment/event that have occurred. All doctors, specialists, eye, and other medical appointments the child attends must be entered into this tab by the CM or with the assistance of WATCH. Regular therapy appointments are also detailed in this tab. All children in out of home care age 3 and older must have dental maintenance appointments documented at minimum every 6 months.

The Case Manager must ensure all supporting documents for the medical/mental health/eye/dental information entered, are obtained and scanned into the client file; as well as filing with the court and attaching to Court Reports such as the Judicial Review Social Study and the Case Plan. The data in the Medical/Mental Health Record is to be entered in by the Case Manager no later than 48 hours after each medical/mental health/eye/dental event. The Medical/Mental Health Record must be filled in completely and maintained up to date.