CFS 691
Rev. 9/04

DATE: _____

State of Illinois
Department of Children and Family Services

Identification of a Child Diagnosed with Asthma

(Please print or type)

Please complete a form for each ward on your caseload who is diagnosed with asthma. Place form in the case file. (Please print or type)

Caseworker Information

Name (Last, First, MI): _____ Team Region/ Site/Field: _____

Supervisor's Name: _____ Phone: _____

DCFS Region/
POS Agency Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Child's Information

Name (Last, First, MI): _____ DCFS ID: _____

DOB: _____ Sex (M/F): _____ Living Arrangement Type: _____

Caregiver's/Residential Facility's Name: _____

Address: _____ Phone: _____

City, State, Zip: _____ County: _____

Primary Care Physician Information:

Name: _____ Phone: _____

Asthma severity classification (check one of the following):
Mild intermittent ☒ Mild persistent ☐ Moderate persistent ☐ Severe persistent ☐

Fax, mail or e-mail this form to the DCFS, Health Services.

DCFS Division of Service Intervention-Health Services
406 E. Monroe, Station # 22
Springfield, IL 62701
Phone: (217) 557-2689
Fax: (217) 557-5796