TRANSITION FROM CARE SUMMARY

Name _____ DOB _____ SS# _____

Address _____
Street City State Zip

Phone _____
Home Work Cell

Emergency Contact _____
Relationship Phone

Guardian/Medical Surrogate _____
Relationship Phone

Primary Insurance: _____
Policy # Case Manager Phone #

Secondary Insurance:_____
Policy # Case Manager Phone #

Unique Communication/Cultural Needs: _____

Strengths/Assets: _____

Assistive Technology: _____

Allergies: _(meds & food)_____

Height: ____ Weight: ____ Dietary/Nutritional Needs: _____

Bowel Program: _____

Bladder Program: _____

Head/Neurology	GI
EENT	GU
Heart/Lungs	MS

Diagnosis	Managing Provider	Address	Phone
1.			
2.			
3.			
4.			
5.			

Current Medications	Current Medications
1.	5.
2.	6.
3.	7.
4.	8.

Recent Labs/ X-Rays	Date	Where on File	Findings

Current Therapies	Frequency	Provider	Contact Information
1.			
2.			
3.			

Medical Equipment	Medical Supplies	Provider	Contact Information
1			
2.			
3.			
4.			

Orthotics & Prosthetics	Provider	Contact Information
1.		
2.		

Past Hospitalizations (including surgeries)

Date	Hospital Name	Reason	Physician

Functional Capabilities	Brief Summary
Upper Extremities	
Lower Extremities	
Speech/Language	
Cognitive/ Problem Solving	
Vision/Hearing	
Walking Endurance	
Standing Endurance	
Lifting Strength	

Future Plans (including agencies involved, referral, appointments made)
Health Care Provider(s)
Health Care Insurance
School & Work
Independent Living (housing, transportation, attendant care)

Services Currently Receiving	Provider Contact Information
1.	
2.	
3.	
4.	

Signature Youth/Guardian: _____ Date Completed: _____

Signature Care Coordinator: _____ Phone #: _____