# Medical Summary

**Child's Name: __________________Date of Birth: _____________Address:____________________**

**Parents/Guardian: ___________________________________________________________________**

**Phone: Home #____________________Cell# ________________Work # ______________________**

**PCP Name _________________________ Phone _______________ Fax # ______________________**

**Principle Diagnosis: _________________________________________________________________**

**Problem List:**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

**Unique Clinical Facts: _______________________________________________________________**

_____________________________________________________________________________________

**Allergies: ___________________________________________________________________________**

**Medications:**
**Chronic (dose/date started/ended)**

1______________________________
2______________________________
3______________________________
4______________________________
5______________________________
6______________________________
7______________________________
8______________________________

**PRN - Medications**

1______________________________ 4______________________________

2______________________________ 5______________________________

3______________________________ 6______________________________

**Consultants/Specialty/Phone#/ Last Visit Date**

1______________________________ 4______________________________

2______________________________ 5______________________________

3______________________________ 6______________________________

**Community:**

School__________________________________ Phone _______________________

Mental Health___________________________ Phone _______________________

Home Care Nursing ______________________ Phone _______________________

Developmental Services__________________ Phone _______________________

**Date of Past Hospital Admits/Reason**

1______________________________ 6______________________________

2______________________________ 7______________________________

3______________________________ 8______________________________

4______________________________ 9______________________________

5______________________________ 10______________________________

**Home Care Equipment:** Company Name________________ Phone _________

__ Feeding pump/supplies
__ Suction machine/supplies
__ GT/GJ (type ____size____)
__ Trach tube type/size ______ / cuff yes/no
__ Car Seat
__ Formula _____________________

__O2 stationary/portable
__ O2 oximeter (SAT)
__ Vent/ Type ______
__ Apnea monitor
__ Wheelchair
__ Other ___________________

**Team Goals: Family Meetings**

1.________________________________

2.________________________________

3.________________________________

4________________________________

5________________________________

6________________________________