Medical Summary/Care Plan

Child's Name: _____ Sex: M F Date of Birth: ____/____/_____

Parents: (Mom)_____(Dad)_____

Address: _____

Phone: Home# (____)_____ Cell# (_____) _____ Work# (_____)_____

PCP name: _____ Phone: (_____)_____ Fax #(_____)_____

Insurance: _____ Emergency Contact: _____

Diagnosis: _____**Complexity Score: _____**

Problem/Concern List:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Unique Clinical Facts/Special Considerations:

_____

_____

Baseline data (physical findings, vital signs, and neurological status):

Physical Findings: _____
Vital signs: _____
Neurological status: _____
Other: _____

Routine labs, x-rays, etc.: _____

Medications:

Chronic (dose/date started/ended)

1._____ 5. _____

2._____ 6._____

3._____ 7._____

4._____ 8._____

PRN- medications

1._____ 3._____

2._____ 4._____

Allergies: _____

Immunizations: up to date _____ needs_____

Date of Past Hospital Admits/Reason:

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4. _____ 8. _____

Consultants/Specialty /phone#/last visit date/how often f/u:

1._____ 5. _____

2._____ 6._____

3._____ 7._____

4. _____ 8. _____

Dentist: _____

Home Care Nursing: Agency Name: _____

Contact: _____ phone: (_____)_____

Services Ordered: _____

Home Care Equipment: Company Name: _____ phone: (_____)_____

__ O2 stationary/portable
__ O2 oximeter (SAT)
__Apnea monitor
__ Suction machine/supplies
__Trach tube type/size _____ / Cuff Yes/No
__Vent/type_____,
__Formula_____
__Feeding pump/supplies
__ N/G tube
__GT/GJ (type_____ size___)
__Car seat
__Wheelchair
__ BP monitor
__ Other_____

Developmental /Rehab: Company Name: _____ phone: (_____)_____

__PT: _____
__ OT: _____
__Speech: _____
__ Vision: _____

School: _____ phone: (_____)_____

Community Resources:

__ DSPD: Caseworker_____ phone: (_____)_____
__ SSI
__ Waiver Program: __Technology Dependent Children __TBI __DDMR
__ Workforce Service: __Food Stamps __Child Care
__ WIC
__ Housing Assistance
__ Medicaid: Caseworker_____ phone: (_____)_____

Mental Health: _____ **phone**: (_____)_____

Other: _____

Team Goals/ Family Meetings: **Last revision date: _____**

1._____ 3._____

2._____ 4._____

Common Emergency conditions with treatment considerations: (Dr. to fill out)