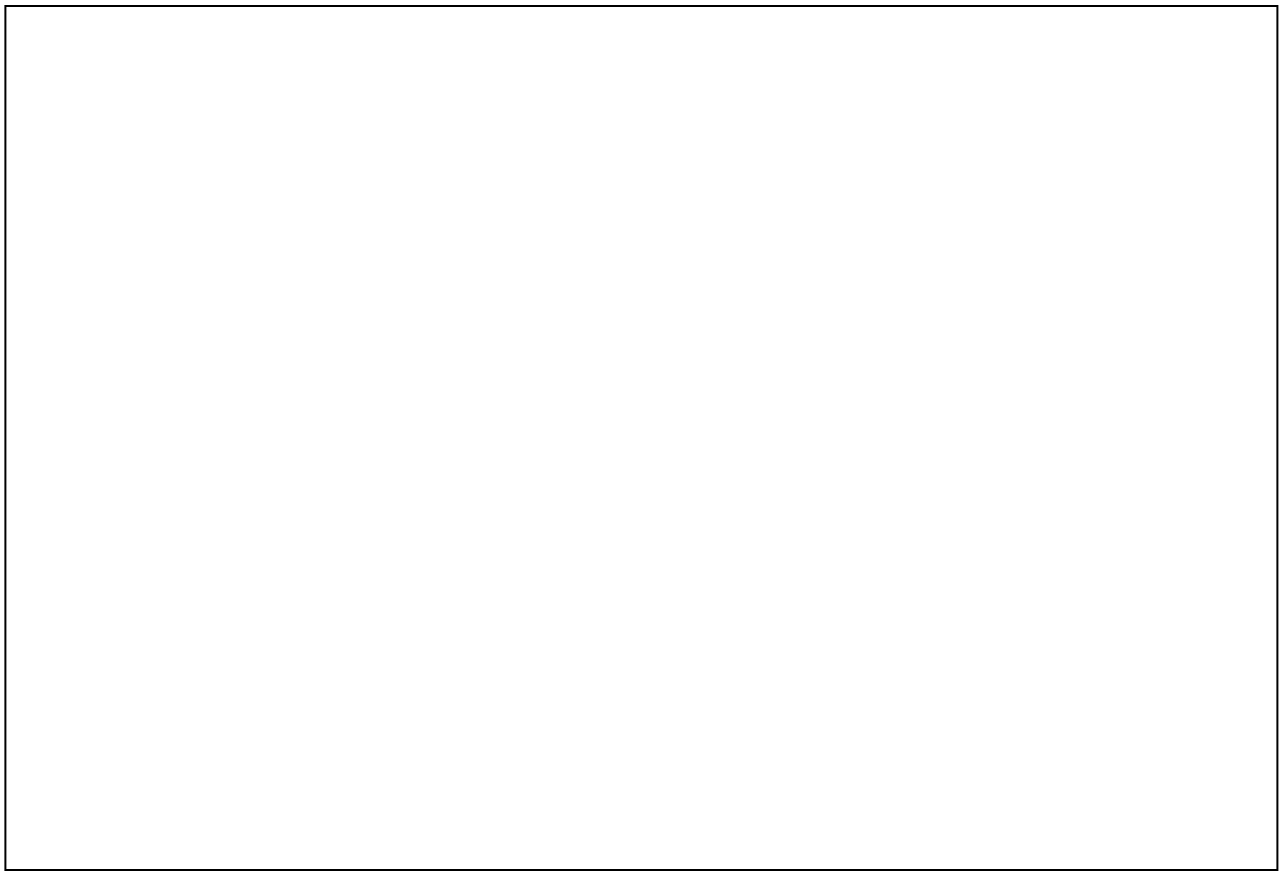
ALL ABOUT



ME!

Table of Contents

Table of Contents
(continued)

Emergency Information:

My Name is: _____ Nickname:_____
My Address is:

_____

Directions to my house:

_____

_____

_____

_____

The language we speak at home:_____

Do I need an Interpreter Yes_____ No _____

~~~~~~

Fire Department Number: 911 or

_____

Police Department Number: 911 or

_____

Ambulance 911 or

_____

Poison Control Hotline

_____

~~~~~~

Fire Escape Plan:_____

_____

_____

_____

~~~~~~

Check smoke alarms monthly!
Check fire extinguishers monthly!
~~~~~~

Family and Friends Emergency Contact Information

Name______________________________________ Relationship__________________________

Address____________________________________ City/Zip_____________________________

Telephone________________________________Day ______________________________Evening

Cell Phone or Alternate number(s)____

~~~~~~

Name______________________________________ Relationship__________________________

Address____________________________________ City/Zip_____________________________

Telephone________________________________Day ______________________________Evening

Cell Phone or Alternate number(s)____

~~~~~~

Name______________________________________ Relationship__________________________

Address____________________________________ City/Zip_____________________________

Telephone________________________________Day ______________________________Evening

Cell Phone or Alternate number(s)____

~~~~~~

Name______________________________________ Relationship__________________________

Address____________________________________ City/Zip_____________________________

Telephone________________________________Day ______________________________Evening

Cell Phone or Alternate number(s)____
~~~~~~

Doctor, Specialist, Pharmacy Contact Information

Primary Care Provider:_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Urgent Care/After Hours Clinic_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Primary Hospital_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Secondary Hospital_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Counselor/Therapist: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Specialist Provider _____ **Specialty:** _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Specialist Provider: _____ **Specialty:** _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Specialist Provider: _____ **Specialty:** _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Dentist: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Physical Therapist: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Occupational Therapist: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Speech-Language Pathologist: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Eye Care Provider: _____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Pharmacy_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~

Pharmacy_____

Address: _____

Phone:_____ Fax: _____

Emergency/After Hours Number: _____

~~~~~~
~~~~~~

TRANSPORTATION:

Agency:____

Address: ____

Phone:_______________________ Fax: __________________________

Emergency/After Hours Number: _____________________________________

~~~~~~

Agency:____

Address: ____

Phone:_______________________ Fax: __________________________

Emergency/After Hours Number: _____________________________________

~~~~~~

Agency:____

Address: ____

Phone:_______________________ Fax: __________________________

Emergency/After Hours Number: _____________________________________

~~~~~~

Agency:____

Address: ____

Phone:_______________________ Fax: __________________________

Emergency/After Hours Number: _____________________________________
~~~~~~

Community Contact Information:

School Name: _____

Grade or year in school: _____

School Phone: _____ Contact Person: _____

Academic Counselor: _____ Phone: _____

~~~~~~

Department of Health and Human Services Case Number: _____

Case Manager/Title: _____

Address: _____

Daytime phone: _____ Evening Phone: _____ Fax:_____

~~~~~~

Other Case Management: _____

Case Manager/Title: _____

Address: _____

Daytime phone: _____ Evening Phone: _____ Fax:_____

~~~~~~

Durable Medical Equipment Company: _____

Case Manager/Title: _____

Address: _____

Daytime phone: _____ Evening Phone: _____Fax:_____

~~~~~~

Church or Religious Community: _____

Contact Person: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Consent for Treatment

Date last updated

Date: _____

In case of emergency, I authorize the following named person(s) listed below to give my consent to be hospitalized, have surgery or receive other necessary healthcare:

Name	**Relationship**

1. _____
2. _____
3. _____
4. _____
5. _____

This permission remains in effect until I change it by completing a new form.

Signature or Legal Guardian **Date**

Signature of Witness (not related to the child or parent/legal guardian

MY STORY

Birth Information

I was born on _____ (Date of Birth). Social Security Number_____/_____/_____

My parent's names are: _____

Things I need help with (like washing, dressing or brushing teeth):_____

_____.

Things I can do for myself (but thanks for asking!):_____

_____

If you need to know something else, ask me or ask _____

Who can be reached by calling: ( ) _____

Important people who take care of me _____

Phone: _____

My Brothers and Sisters:

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Medical History (You can ask your doctor or nurse to help you fill this out)

Nutrition / Diet: Last Updated _____

_____

_____

_____

_____

Important Baseline Information (Sats, neurological baseline, etc.)

_____

_____

_____

_____

_____

_____

_____

Durable Medical Equipment (DME) / Appliances and Providers

_____

_____

_____

Hospital Stays Approximate Dates

1._____

2._____

3._____

4._____

5._____

Surgeries / Procedures Approximate Dates

1._____

2._____

3._____

4._____

5._____

Other Treatments

_____

_____

_____

Medicines/Allergies

Pharmacy Name: Phone: Fax:

_____ _____ _____

(Write meds in pencil only, please)

Current Medicines I'm taking	How do I take it, How much, How often
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications that didn't work: (ALLERGIES)

Name of Drug	Date Started	Date Ended	How much/ How often	Reason for Stopping

Immunization and Preventable Disease History

Insert a copy of your immunization record here.(Shot record)

Disease History:	**Immunizations and date given:**
Chicken Pox _____	_____
Hepatitis B _____	_____
Hepatitis A _____	_____
Other _____	_____
Other_____	_____
Other_____	_____
Other_____	_____
Other _____	_____

This would be a good place to put your records of your immunizations and other information of the medication you are taking.

Family Medical History

Talk about your family; mother, father, grandparents, sisters and brothers. If you know of medical problems that any family has had be sure to write about their experience.

Thinking About Your Future

Circle, check or complete the answer that is true for you.

1. Education and Employment

What are your plans for the next five years? (Check all that apply)

- ❒ Get a job/keep working
- ❒ Go to/finish high school
- ❒ Go to/finish a vocational, technical or other training program.
- ❒ Go to/finish a community college (2-year college)
- ❒ Go to/finish a 4-year college or University
- ❒ Other: _____

What kind of jobs would you like to have?

_____

_____

_____

2. Living Arrangements

As an I adult, I plan to live (Check the one best answer)

- ❒ In my own house or apartment (by myself or with a spouse or roommates)
- ❒ With my parents
- ❒ With other members of my family (brother, sister, aunt)
- ❒ In supported community housing (group home)
- ❒ Another place (specify): _____

3. Living independently

As an adult, I think I will:

Manage my own money	Yes	No
Be financially independent; self-supporting	Yes	No
Be independently mobile in my home	Yes	No
Be independently mobile in the community	Yes	No
Drive a car or van	Yes	No
Manage a household	Yes	No
Get married or have a steady partner	Yes	No
Raise a family	Yes	No
Maintain friendships	Yes	No
Communicate well with health care providers	Yes	No
Arrange for and manage my own health care.	Yes	No
Pay for my own health insurance	Yes	No

4. Planning

I talk with my parents about my future.	Yes	No
I talk with my friends about my future.	Yes	No
I talk with my doctors and/or other professionals about my future	Yes	No

Other Transition Areas To Consider:

Other questions to answer are:

• Do I need a vocational rehabilitation advisor to transition from school to work? If yes…

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

_____

_____

_____

_____

• Do I need an independent living advisor to transition from home to adult living? If yes…

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

_____

_____

_____

_____

Do I need any additional help transitioning from secondary school to college or technical school? If yes…

Name of Contact: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

_____

_____

_____

_____

• Do I need help managing my transportation needs in order to meet my transition goals? If yes…

Name of Social Worker: _____

Phone number: _____

Date Contact Initiated: _____

First Meeting Date: _____

TO DO List Prior to the First Meeting:

_____

_____

_____

_____

Preferences: Likes and Dislikes

My hobbies are:

_____

_____

_____

_____

My favorite things to do:

_____

_____

_____

_____

Activities I am involved in _____

_____

_____

I am unique because _____

_____

_____

_____

_____

Financial and Insurance Information/Considerations

Include a copy of your Insurance Card and Social Security Card in this Section

Ask Yourself:
- Do I need a referral?
- Does my insurance change with age or school status?
- Does my insurance change with employment status?
- If my insurance changes, are there certain services that will be less available after I reach a certain age?

IF YOU CAN'T ANSWER THE QUESTIONS ABOVE
THE TIME TO FIND OUT ABOUT YOUR COVERAGE IS NOW!!

~~~~~~

Primary Insurance: _____ Plan number: _____

Group number: _____ ID number: _____

Subscriber's name: _____

Subscriber's Social Security Number: _____

Mailing address: _____

Phone: _____ Fax: _____

~~~~~~

Secondary Insurance: _____ Plan number: _____

Group number: _____ ID number: _____

Subscriber's name: _____

Subscriber's Social Security Number: _____

Mailing address: _____

Phone: _____ Fax: _____

~~~~~~
~~~~~~

Other Insurance: _____ Plan number: _____

Group number: _____ ID number: _____

Subscriber's name: _____

Subscriber's Social Security Number: _____

Mailing address: _____

Phone: _____ Fax: _____

Other Financial Information:

_____

_____

_____

_____

_____

_____

_____

Place any important information or papers in the divided folders or plastic sheets to keep from losing the information.

- Do I have any other needs that need to be met prior to implementing my Transition plan? If yes list them here and talk to your doctor.

_____

_____

_____

_____

_____

_____

Congratulations!!

You're ready to Transition!

Appointment Log

Steps to a satisfactory medical appointment:

1. Write down your problems/questions before you go.
2. Number the problems in questions. Make the number one the most important.
3. Show the provider your list. Write down any answers to your questions.
4. Talk to the provider about options for handling your problems/questions

---

DATE	PROVIDER	QUESTIONS/PROBLEMS TO BE DISCUSSED	REASON SEEN/ CARE PROVIDED	NEXT APPOINTMENT

NOTES

NOTES

MONTHLY CALENDAR

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

RESOURCES

For more information about special health care services for children and youth, please refer to the following websites and phone numbers

Oklahoma Department of Human Services	**www.okdhs.org (405) 521-3646**
Oklahoma Developmental Disabilities Council	**http://www.okddc.ok.gov (800) 836-4470**
Community Leadership and Advocacy, Center for Learning/Leadership/UCEDD	**http://w3.ouhsc.edu/thecenter (800) 627-6827**
Maternal and Child Health Service	**http://www.health.state.ok.us (405) 271-4480**
Office of Juvenile Affairs	**www.oja.state.ok.us (405) 530-2800**
Oklahoma Commission on Children/Youth	**www.okkids.org (866) 335-9288**
Oklahoma Department of Mental Health and Substance Abuse Services	**www.odmhsas.org (405) 522-3908**
Oklahoma Department of Rehabilitation	**www.okrehab.org/ (800) 845-8476**
Oklahoma Family Network Inc.	**www.oklahomafamilynetwork.org (405) 271-4500**
Oklahoma Health Care Authority	**www.okhca.org (800) 522-0310**
Oklahoma State Department of Education	**www.sde.state.ok.us (405) 521-3301**
Oklahoma State Department of Health	**http://www.health.state.ok.us (800) 522-0203**
Special Education Services	**www.sde.state.ok.us (405) 522-3248**
STARS (Statewide Training and Regional Support)	**www.ah.ouhsc.edu/tolbert/courses_workshops/ (405) 271-1836**

Additional websites:

ADA Accessibility Guidelines: http://www.access-board.gov/adaag/html/adaag.htm

Autism Society of America: http://www.autism-society.org/site/PageServer

Down Syndrome Association of Central Oklahoma: http://www.dsaco.org/

Down Syndrome Association of Tulsa: http://www.dsat.org/

IDEA (Individuals with Disabilities Education Act 2004): http://www.nichcy.org/idealaw.htm

IMPACT-Articles on Autism Spectrum Disorder: http://ici.umn.edu/products/impact/193/default.html

Natural Resources: http://www.fpg.unc.edu/~scpp/nat_allies/na_resources.cfm

NICHY (National Dissemination Center for Children with Disabilities): http://www.nichcy.org/

OASIS (Oklahoma's Statewide Information and Referral System): http://oasis.ouhsc.edu/

Oklahoma Assistive Technology Center: http://www.theoatc.org/

Oklahoma Autism Network: http://www.okautism.org/

Oklahoma Deaf-Blind Technical Assistance Project: http://www.ou.edu/okdbp/techserv.html

Oklahoma Medical Home (resources for families and providers): http://www.medicalhomeportal.org/

Oklahoma Yellow Page for Kids: http://www.yellowpagesforkids.com/help/ok.htm

Special Education Policies and Procedures: http://www.sde.state.ok.us/pro/spedpp.html

Special Quest: http://www.specialquest.org/

The RISE School: http://www.riseschool.org/

Tulsa Autism Foundation: http://www.autismtulsa.org/home/index.cfm

US Department of Education: http://www.ed.gov/index.jhtml

See enclosed pamphlet for 211 – A quick guide to Social Services

For more information about Sooner SUCCESS visit our website at www.oumedicine.com/soonersuccess