Pediatric Care Coordination "Assessment"

Child's Name_________________________ Family Name ___________________________Date___________

1) What would you like us to know about your child?
(What does he/she do well? Like? Dislike?)?

2) What would you like us to know about you/your family?

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3) Do you have any concerns or worries for your child? (Some examples below)

- ❑ Their growth/development
- ❑ Learning
- ❑ Sleeping
- ❑ Self-care
- ❑ Making and keeping friends
- ❑ Other_(fill in): ____
- ☐ Doing things for themselves
- ☐ Falling behind in school
- ☐ Behavior
- ☐ The future
- ☐ Playing with friends

4) Have there been any changes in your family since we saw you last, such as a:

- ❑ Brother of sister leaving home?
- ❑ Move to a new town?
- ❑ Sickness or death of a loved one?
- ☐ New job or job change?
- ☐ Separation or divorce?
- ☐ Other (fill in below)?

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5) Can we help you with any of the following needs?

- ○ **Medical Needs** (For example, help finding or understanding medical information; help finding health care for yourself or your family)?
- ○ **Social Needs** (For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family)?
- ○ **Educational Needs** (For example, explaining your child's needs to teachers; help reading or understanding medical information)?
- ○ **Financial Needs** (For example, understanding insurance or finding help paying for needs that insurance does not cover - such as medications, formulas, or equipment)?
- ○ **Legal Needs** (For example, discussing laws and legal rights about your child's health care or their school needs)?

6) What do you want or need? (We will work with you to find answers if we can).
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