**Completed by:** Click here to enter text. **Last updated:** Click here to enter text.

**Utah Pediatric Shared Plan of Care** Template

To be used with the

Care Coordination Information Checklist

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information:** | | | | | | | | | | | | |
| **Complexity Level**: Choose one  **Insurance:** Insurance Policy **Chart Number:** Number | | | | | | | | | | | | |
| **Patient Name:** Click here to enter text.  **Date of Birth:** Click here to enter text.  **Parent:** Click here to enter text.  **Relationship:** Click here to enter text. **Phone:** Click here to enter text. | | | | | | | | | | | | |
| **Educational Information:** | | | | | | | | | | | | |
| **School Name:** Click here to enter text.  **Grade:** Click here to enter text.  **Person of contact:** Click here to enter text. **Phone:** Click here to enter text.  **School Information:** Click here to enter text. | | | | **Current Plans:**  IFSP  IEP  504  IHP | | | | | | | | |
| **Challenges:** | **Equipment Needs/Assistive Technologies:** | | | | | | | **Special Clinical Accommodations:** | | | | |
| Behavioral   Learning   Physical Anomalies   Respiratory   Communication   Sensory  Orthopedic/Musculoskeletal   Feeding/Swallowing   Hearing/Vision   Stamina/Fatigue  Social  Sleeping  Nutrition  Education   Other: Click here to enter text. | Gastronomy   Adaptive Seating   Wheelchair   Orthotics   Stander/Walker  Crutches/Braces  Feeding Pump   Tracheostomy   Suction   Nebulizer  Communication Device   Hearing Aids/Cochlear  Monitors:  Apnea O2 Glucose Cardiac  Other: Click here to enter text. | | | | | | | Room immediately   Dim lighting   Low volume   Sensory toys  Minimize wait   Picture communication   Wheelchair access   Other: Click here to enter text. | | | | |
| **Current Services:** | | | | |
| Early Intervention  Transition  SPED  SLP  PT  OT  APE  PSY  Home Health  Other: Click here to enter text. | | | | |
| **Chronic Condition Management:** | | | | | | | | | | | | |
| **Problem List:** | | | | | | | | | | | | |
| **Diagnosis** | | | | | | | | | | | **ICD-10 Code** | |
| primary diagnosis. | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| Secondary diagnosis | | | | | | | | | | | ICD 10 code | |
| **Treatment:** | | | | | | | | | | | | |
| **Clinical Goals / Action Items** | | **Date of Last Visit** | | | **Need notes?** | | **Specialist/Care Provider Responsible** | | | | | **Follow-Up Date** |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
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| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| **Behavioral Goals / Action Items** | | **Date of Last Visit** | | | **Need notes?** | | **Specialist/Care Provider Responsible** | | | | | **Follow-Up Date** |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| **Social or Community Goals / Action Items** | | **Date of Last Visit** | | | **Need notes?** | | **Specialist/Care Provider Responsible** | | | | | **Follow-Up Date** |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| **Educational Goals / Action Items** | | **Date of Last Visit** | | | **Need notes?** | | **Specialist/Care Provider Responsible** | | | | | **Follow-Up Date** |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| **Financial Goals / Action Items** | | **Date of Last Visit** | | | **Need notes?** | | **Specialist/Care Provider Responsible** | | | | | **Follow-Up Date** |
| Click here to enter text. | | Click here to enter text. | | |  | | Click here to enter text. | | | | | Click here to enter text. |
| **Medications:** Click here to enter text. | | | | | | | | | | | | |
| **Name** | | | **Dosage** | | | | | | **Frequency** | | | |
| Click here to enter text. | | | Click here to enter text. | | | | | | Click here to enter text. | | | |
| Click here to enter text. | | | Click here to enter text. | | | | | | Click here to enter text. | | | |
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| **Allergies:** Click here to enter text. | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | |
| **Recent Labs:** Click here to enter text. | | | | | | | | | | | | |
| **Type** | **Result** | | | | | | | **Date** | | | | |
| Click here to enter text. | Click here to enter text. | | | | | | | Click here to enter a date. | | | | |
| Click here to enter text. | Click here to enter text. | | | | | | | Click here to enter a date. | | | | |
| Click here to enter text. | Click here to enter text. | | | | | | | Click here to enter a date. | | | | |
| Click here to enter text. | Click here to enter text. | | | | | | | Click here to enter a date. | | | | |
| **Care Team Information:** | | | | | | | | | | | | |
| **Provider** | | **Location** | | | | **Phone** | | | | **Fax** | | |
| **PCP:** Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | |
| **Specialist:** Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | |
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| **Specialist:** Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | |
| **Agency:** Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | |
| **Agency:** Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | | |
| **Home Nursing/Respite Care?**  Yes  No | | | | | | | | | | | | |
| **If yes, organization & phone:** Click here to enter text. | | | | | | | | | | | | |

Do you consent to share with the Care Team members / agencies above?

Microsoft Office Signature Line...  
----------------------------------------------------------------------------------------------------------------------

