

Last review and update:

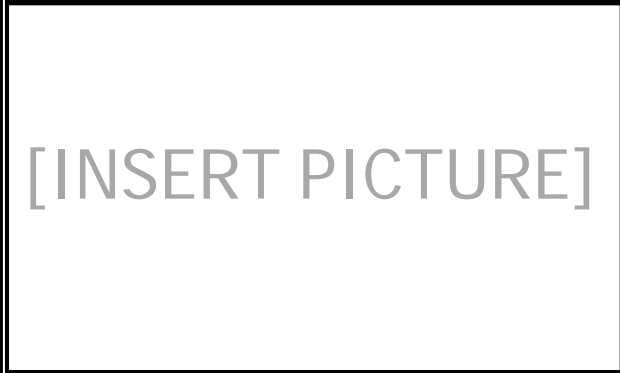
Shared Plan of Care (Medical Summary & Negotiated Actions)

****SEE EMERGENCY CARE INFORMATION ON PAGE 2****

PATIENT INFORMATION

First Name: Last Name: Middle: Sex: Birthdate: Age: MRN/System:

ABOUT ME



Strengths & preferred activities:

How I learn:

Interaction tips:

Communication style:

Tips to avoid triggers/behaviors:

Mobility:

DEMOGRAPHIC INFORMATION

Primary contact last name: First: Relationship to patient:

Street Address: City: County: State: Zip:

Mailing Address: City: State: Zip:

Email (Preferred? Y N): Phone (Preferred? Y N): Secondary Phone (Preferred? Y N):

Legal Decision Maker Information:

Emergency Contact Information:

Insurance Information

Primary insurance: ID number:

Policy holder: Employer: Policy holder birthdate:

Secondary insurance: ID number:

Policy holder: Employer: Policy holder birthdate:

Waiver Type: Waiting List Date applied:

Medicaid redetermination date:

Who are the people living in your home(s)? (Include you, and any other children or adults living with you.)

Primary Household

Secondary Household

First and last names	Age	Relationship to your child	First and last names	Age	Relationship to your child
Self		Self			

Last review and update:

ALERTS

EMERGENCY/ADVANCED CARE INFORMATION:

**If needed, please see attached emergency or advanced care plan.*

MEDICATION ALLERGIES:

VITAL SIGNS

Height:		Weight (date):	
Baseline BP/HR:		Baseline RR:	
BMI:		Percentile:	
		Z-score:	

CONDITIONS & MEDICAL HISTORY LIST

DIAGNOSIS	DATE OF DIAGNOSIS	DIAGNOSIS	DATE OF DIAGNOSIS
Birth/Genetic:		Cardiovascular:	
Dental:		Endocrine:	
Ears, Nose, and Throat:		Gastrointestinal:	
Genitourinary:		Hematology:	
Infectious Disease:		Musculoskeletal:	
Neurologic:		Ophthalmology:	
Psychiatric/Psychological:		Renal:	
Respiratory:		Skin:	
Neurodevelopmental:		Behavioral:	

MEDICATIONS & TREATMENTS

Medication name	Form	Dose	Time of day	Reason	Route (by mouth unless noted). Other comments:

Last reconciled:	
Special medication instructions:	
Treatment Plan:	
Medication History:	
Allergies:	
Diet:	
Current Equipment:	
Equipment Needs:	

PROFESSIONALS & SERVICES

Primary care clinician:		Phone:		Fax:	
Non-clinician contact:		Phone:		Email:	
					Last visit:
Street Address:	City:	State:	Zip:	Practice:	
Preferred pharmacy:		Phone:		Fax:	
Preferred hospital:		Phone:		Fax:	

Last review and update:

OTHER PROVIDERS	NAME/TYPE/LOCATION	LAST VISIT	REASON FOR SERVICE	CONTACT INFORMATION
Specialist 1:				
Specialist 2:				
Specialist 3:				
Specialist 4:				
Psych / Behavior:				
Dentist:				
Vision:				
Therapy (OT/PT/etc.):				
Hearing:				
Home Care:				
Community agency:				
Government services:				
Waiver/Other case manager:				
Equipment/Vendor:				

IMMUNIZATIONS

DTaP/DTP/TD							
OPV/IPV				HPV			
MMR		Varicella			Hep A		
Hep B			Meningococcus				
PPD			Pneumovax				
Flu							
HIB			Rotovirus		Tdap		

FAMILY MEDICAL HISTORY

<u>Condition</u>	<u>Who?</u>	<u>Condition</u>	<u>Who?</u>	<u>Condition</u>	<u>Who?</u>
Coronary Artery Disease:		Hypertension:		Diabetes:	
Mental Health:		Cancer Type:		Genetic:	
Neurodevelopmental:		Lipids:		Other:	

NOTES:

HOSPITALIZATIONS (date, reason, location if known)

SURGERIES (date, reason, location if known)

PROCEDURES (labs, imaging, etc.)

DIAGNOSIS SPECIFIC MONITORING

Last review and update:

ABOUT MY FAMILY

Race/Ethnicity:	
Unique family attributes:	
Family description of health condition:	
Family's support "system"	
Family life stressors:	
Housing:	<input type="checkbox"/> Own <input type="checkbox"/> Rent
Emergency exit plan (fire, tornado, etc.):	
Transportation access/safety:	
Caregivers' occupations:	
Family financial concerns:	

SCHOOL

Current setting:	First Steps:	Head Start:	Preschool:
	K-12; Grade:	Homeschooled:	Other:
Current school name:		Current School District:	
Primary Contact:	<input type="checkbox"/> Classroom teacher	<input type="checkbox"/> Teacher of Record	<input type="checkbox"/> Other:
Contact name:		Contact Email:	Contact Phone:
Previous setting:	First Steps:	Head Start:	Preschool:
	K-12; Grade:	Homeschooled:	Other:
Previous school name:		Previous School District:	
Services:	<input type="checkbox"/> Has a 504 Plan <input type="checkbox"/> Gifted services <input type="checkbox"/> Other:	<input type="checkbox"/> Has an individualized education plan (IEP/IFSP) <input type="checkbox"/> Physical therapy (PT)	<input type="checkbox"/> Behavioral Intervention Plan <input type="checkbox"/> Occupational therapy (OT) <input type="checkbox"/> Response to intervention (RTI) <input type="checkbox"/> Speech

Educational History:

CHILDCARE

Childcare type:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> In-home <input type="checkbox"/> Center-based <input type="checkbox"/> Voucher supported <input type="checkbox"/> Respite only				
Primary contact:	<input type="checkbox"/> Classroom teacher <input type="checkbox"/> Director <input type="checkbox"/> Other:				
Contact name:		Contact Email:		Contact Phone:	

NOTES/OTHER

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Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Resolved (Date)
Family Personal Goals & Priorities			
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
Collaboration with/request from primary care and community			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
Clinical Goals & Priorities			
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped
Collaboration with/request from primary care and community			<input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> On Hold <input type="checkbox"/> Dropped

Parking Lot/Future Goals

<p>Family Signature:</p> <p>Date:</p>	<p>Clinician Signature:</p> <p>Date:</p>	<p>Care Coordinator Signature:</p> <p>Date:</p> <p>Care Coordinator: Phone: Email:</p>
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