

Last review and update:

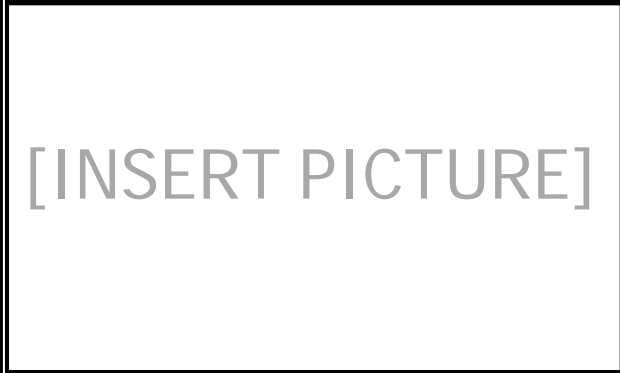
## Shared Plan of Care (Medical Summary & Negotiated Actions)

**\*\*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:	
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)
<b>Family Personal Goals &amp; Priorities</b>			
			<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
<b>Clinical Goals &amp; Priorities</b>			
			<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><b>Family Signature:</b></p>  <p><b>Date:</b></p>	<p><b>Clinician Signature:</b></p>  <p><b>Date:</b></p>	<p><b>Care Coordinator Signature:</b></p>  <p><b>Date:</b></p>  <p><b>Care Coordinator:</b>  <b>Phone:</b>  <b>Email:</b></p>
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