Hillsboro Pediatrics

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Patient Medical Summary

Patient Name: **Date of Birth:**
Primary Language: **Ethnicity:**
Insurance: **Group #** **ID#**

Parent/Guardian Name:
Address:
Phone Number: (home): **(cell):** **(work)**
Parent/Guardian Name:
Address:
Phone Number: (home): **(cell):** **(work)**
Emergency Contact:

- **Name:**
- **Phone Number:**

Patient's PCP
HPC Care Coordinator:
Office Phone Number: (503)640-2757
Office Address: 445 E. Main St, Hillsboro, OR 97123

Hillsboro Pediatric Clinic LLC
Phone # (503)640-2757
Office FAX Number: (503)640-9753

Chronic Health Conditions/Problem List:

1. **5.**
2. **6.**
3. **7.**
4. **8.**

Past Hospitalizations/Surgeries/Reason/Date:

1. **5.**
2. **6.**
3. **7.**
4. **8.**

Allergies:

Medications:

1. **6.**
2. **7.**
3. **8.**
4. **9.**
5. **10.**

Consultant/Specialty/Phone #/Last Visit Date:

1.
3.
4.
5.
6.

Community Resources:

School: **Phone:**
Mental Health: **Phone:**
Home Care Nursing: **Phone:**
Developmental Services: **Phone:**
PT: **Phone:**
OT: **Phone:**
Speech: **Phone:**
Vision: **Phone:**
CSD Caseworker: **Phone:**
Medicaid Caseworker: **Phone:**
Other: **Phone:**

Home Care Equipment:

Company Name: **Phone:**
__Port type:
__Feeding pump/supplies
__GT/GJ type: **size:**
__Formula/nutritional supplement (type):
__Trach tube type: **size** **cuffed? yes/no**
__Suction machine/supplies
__Vent/Type:
__O2 stationary/portable
__O2 oximeter

		Date	Date	Date
Family's #1 concern:				
Provider's #1 concern:				
Goal(s):				
Family Strengths:				
Barriers to Success:				
Other pertinent information:				
Plan to achieve goal/person responsible to perform :				
1. Patient				
2.Family				
3. Provider				
4.Care Coordinator				
Re-evaluation date:				
RN Name:				
Parent Signature:				
Provider Signature:				

References:
Medicalhomeportal.org
Massgeneral.org

Example of Goals for the Care Plan

Asthma

Examples of ***Patient Goals***

1. Carry albuterol canister with child or near her at all times, including having 1 at school.
2. Try best to void all allergens that trigger their asthma, ie. Smoking, dust, mold, etc…
3. Learn and memorize the asthma action plan, so it can be utilized when needed. Keep a copy at home and at school.
4. Exercise 60 minutes/day-develop a consistent exercise regimen. Do the best that they can-remind child of this. Know when medication is needed!
5. Take medicine as needed and daily if scheduled daily inhaler.

Examples of ***Family Goals***

1. Stop smoking and reduce/eliminate allergens in home, if this is applicable
2. Know what to do when asthma symptoms develop-know the asthma action plan. Keep a copy in each major room in the home.
3. Make sure child is taking medication as ordered.

Examples of ***Provider Goals***

1. Have family and child keep an asthma diary (how asthma is doing and what is triggering asthma symptoms)-have them bring this with them to visit.
2. Educate child and family on how to use nebulizers, inhalers, and meds.
3. Discuss and review asthma action plan with each visit.

Examples of ***Care Coordinator Goals***

1. Link family with support resources or referrals for asthma specialists within 1 month, if needed.
2. Make sure child is getting yearly flu shot. Child is coming for flu shot in 1/2013 and asthma re-call appointment.

BMI

Examples of ***Patient Goals***

1. Engage in 60 minutes of physical activity per day. Have the pt. do the best that the pt. can-working up to this goal.
2. Make healthier food choices-go to choosemyplate.gov and find ways to lessen portion size and make healthier choices.
3. Join a sports team at school or in the community that will increase physical activity.
4. Decrease screen time (watching television and playing on the computer) to less than 2 hours per day. Change to video games that involve dancing or moving around.

Examples of ***Family Goals***

1. Act as a role model for nutrition and physical activity-exercise with their child as much as possible.
2. Do not use food or television as rewards.
3. Eat together as a family as much as possible.
4. Limit screen time to less than 2 hours today, have the child play outside and/or involve child in sports.
5. Limit eating out; make it more a “special” event. 1 time per week.
6. Promote the child to drink more water and limit juice. Encourage low fat milk, over 2 years old.
7. Keep a diary of exercise, diet, and/or BP’s as suggested by care provider. Utilize pedometer as ordered.

Examples of ***Provider Goals***

1. Monitor weight, BMI and risk factors at each visit. Order necessary labs.
2. Promote use of pedometer and encourage at least 10,000 steps per day.
3. Educate the patient family how to incorporate healthier choices and provide resources that the family can seek out for education.
4. Have the patient make a diary of daily activity and BP’s, bring with each visit.

Examples of ***Care Coordinator Goals***

1. Provide resources and educational handouts related to exercise, diet, and healthy life choices within 2 weeks of visit.
2. F/U with family within 2 weeks of visit to see how the child is doing.

References:
Medicalhomeportal.org
Massgeneral.org

3. Refer to needed therapies within 1 month.

Depression

Examples of ***Patient Goals***

1. Take meds as ordered (if ordered). Do not abruptly stop them!
2. Involve self in activities pt. enjoys, 20-60 minutes daily, ie sports, music, hanging out with friends
3. For every "sad feeling," think of a "good feeling." Keep a diary of this and bring to MD/NP visits.

Examples of ***Family Goals***

1. Be positive at home, validate the child's feelings when child's efforts fail.
2. Have family time, spend at least 2-3 dinners per week eating together at the table. Do at least 1 family activity per week.
3. Make sure child is going to counseling sessions as scheduled, pt. and family.

Examples of ***Provider Goals***

1. Reassure pt. you are there as a resource if they need to talk-give contact info you want them to have.
2. Contact pt. yourself in 2 weeks to F/U with patient's progress.

Examples of ***Care Coordinator Goals***

1. F/U with family within a few days (3-5 days) following appt to see how patient is doing.
2. Initiate family contacts, create on-going process for families to determine what level of care-coordination they want (give office, care coordinator, direct, and referral numbers).
3. Speak with school counselor to coordinate academic needs within 1 month. Have counselor check on child.
4. Provide online resources the child can go to online for assistance.

PTSD

Examples of ***Patient Goals***

1. Patient will engage in therapy sessions that are provided and use those interventions as suggested by therapy in home and school settings.
2. Patient will take medication (if any) as ordered, without skipping doses.
3. Become involved in group activities, such as sports, music, camps.

Examples of ***Family Goals***

1. Keep the child involved in routine, scheduled family activities, such as organizing family trips.
2. Help the child make short-term and long-term goals towards school, life plans, and activities. Make goals that the family can work on as a whole. Work with the school counselor to assist in making these goals. Meet with the counselor after diagnosis to make a plan for school.
3. Be a good role model towards establishing positive behaviors and thinking in the home.
4. Make sure child is taking meds as ordered by MD (if ordered).

Examples of ***Provider Goals***

1. Provide resources that family can obtain for understanding PTSD and how it affects the child's life.
2. Work with a mental healthcare provider to organize a treatment plan for the child. Follow-up with the healthcare provider every couple months.
3. Suggest the child become involved in Cognitive Behavioral Therapy (CBT) and/or play therapy with a mental healthcare provider.

Examples of ***Care Coordinator Goals***

1. Provide resources for patient and family that will help them cope and manage this diagnosis.
2. F/U with family 2 weeks after initial diagnosis to see how pt. and family are doing.
3. Work along with school counselor to organize a treatment plan through the school. F/U with counselor every couple months.
4. Provide necessary referrals and setting for CBT within 1 month of diagnosis.

References:
Medicalhomeportal.org
Massgeneral.org

ADHD

Examples of ***Patient Goals***

1. Take medication as ordered by provider.
2. Engage in activities, recreational or competitive sports, or camp activities.
3. Complete activities suggested by provider, family, and/or therapist.

Examples of ***Family Goals***

1. Reward immediately following a desired behavior (small treats, stickers, inexpensive toys). For undesirable behavior, take away a privilege (screen time, time-outs) immediately following behavior.
2. Become educated about ADHD, understand the facts/myths of diagnosis, the causes of behaviors, behavior management, and knowing when to praise/discipline.
3. Make sure patient's meds are refilled, refills are made on time, and meds are at school.
4. Have designated family time, eat meals together as much as possible, and engage in family activities (hikes, picnics).
5. Keep meals and schedules at home as routine as possible.

Examples of ***Provider Goals***

1. Recognize and validate the difficulties the parents are facing with patient and facilitate healthy coping through information and knowledge of community resources
2. Monitor patient's medication dosing; follow up with B/P's and weight and side effects. Make sure patient is having their follow up appointments as needed

Examples of ***Care Coordinator Goals***

1. Family to call back to Care Coordinator if there are any questions or concerns
2. Link family with support groups, resources and referrals for ADHD within one month of appointment

References:
Medicalhomeportal.org
Massgeneral.org