National Home for Medical Home Implementation

www.medicalhomeinfo.org

Medical Summary Part I

Pediatric Care Plan

Child's Name | **Nickname** | **DOB**

Parent *Caregiver* | Relationship

Address

Home Phone *Blocked?* ◯ *Y* ◯ *N* | Best Time to Reach | E-mail

Mother Alternate Phone | Father Alternate Phone

Emergency Contact | Phone | Relationship

Emergency Contact | Phone | Relationship

Health Insurance/Plan | Identification #

Diagnoses **Emergency Plan?** ◯ **Yes** ◯ **No** **Complexity Level** _____

Primary	ICD9	Primary	ICD9
Secondary	ICD9	Secondary	ICD9
Secondary	ICD9	Secondary	ICD9

Allergies/Reaction _____

Medications/Dose _____

PCP | **Phone** | **Fax** | **E-Mail**

Specialist/Specialty	Clinic/Hospital	Phone	Other *Fax, E-mail, Etc.*
#1			
#2			
#3			

Nursing Service/Respite | Phone

NATIONAL CENTER FO
MEDICAL HOM
IMPLEMENTATIO

Specialized Emergency Information

Child's Name _____ Nickname _____ DOB _____

Common Presenting Problems/Findings with Specific Suggested Managements

See specialist letter(s) attached.

Problem #1 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Problem #2 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Problem #3 _____

Presenting Signs & Symptoms _____

Suggested Diagnostic Studies _____

Treatment Considerations _____

Comments on Child, Family, or Other Specific Medical Issues

_____

_____

_____

_____

_____

Physician/Provider Signature _____ Print Name Above _____

Family/Guardian Signature Giving Consent for Release of this Information to the Emergency Room _____ Print Name Above _____

Care Plan Part II: Child Description

Child's Name _____ Nickname _____ DOB _____

Child's Assets & Strengths _____

Vital Sign *Baselines*

Ht _____ Wt _____ Temp _____ Other _____

Challenges Check all that apply, please explain on lines below.

- ☐ Behavioral
- ☐ Communication
- ☐ Feed & Swallowing
- ☐ Hearing/Vision
- ☐ Learning
- ☐ Orthopedic/Musculoskeletal
- ☐ Physical Anomalies
- ☐ Sensory
- ☐ Stamina/Fatigue
- ☐ Respiratory
- ☐ Other _____
- ☐ Other _____

Procedures to Be Avoided _____

Foods to Be Avoided _____

Activities to Be Avoided _____

Prior Surgeries/Procedures

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

Most Recent Labs/Diagnostic Studies

Labs _____

Drug Levels _____

MRI/CT _____

EEG _____

EKG _____

X-Rays _____

C-Spine _____

Other _____

Other _____

Care Plan Part II: Child Description *(cont.)*

Equipment/Appliances/Assistive Technology Please check all that apply and use the lines below to explain.

☐ Gastrostomy	☐ Nebulizer	☐ Monitors: (✓) ___Apnea ___O2 ___Cardiac ___Glucose	☐ Crutches
☐ Tracheostomy	☐ Adaptive Seating	☐ Wheelchair	☐ Walker
☐ Suction	☐ Communication Device	☐ Orthotics	☐ Other

_____
_____
_____
_____
_____

School System/Child Care _____

Contact Person/Role _____

Phone _____

Family Information

Caregivers _____

Siblings _____

Other Important Facts _____
_____
_____
_____
_____

Special Circumstances/Comment/What You Would Like Us to Know

_____
_____
_____
_____
_____
_____
_____

Parent /Caregiver Signature & Date

Primary Care Provider Signature & Date

Developed by the Center for Medical Home Improvement/Dartmouth Hitchcock Clinic-Concord