**Shared Plan of Care**

 **\*Medical Summary\***

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| --- |
| ABOUT ME |
|  | Last Name: | Middle: | Sex: | Birthdate: | Age: | Medical Record Number (System): |
|  |  |  |   |  |  |   |
| **[Attach Photo Here]** | **Things I like and things I’m good at** |
|  |
| **Best way to talk or connect with me** |
|  |
| **How I get around** |
|  |
| **Helpful tips for a good visit** |
|  |
| **Safety Concerns** |
|  |
| About My Family |
| Primary Caregiver: | Relationship: | Phone:  | Email: |
| Street Address: | City: | State: | Zip: | County: |
| Secondary Contact: | Relationship: | Phone:   | Email: |
| Street Address: | City: | State: | Zip: | County: |
| Legal Decision Maker(s): | Emergency Contact Person (Relationship): | Phone: |
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| Preferred Communication: |  |
| Transportation Means: |  |
| Caregiver’s learning preferences: | [ ]  Reading [ ]  Spoken Info/instruction [ ]  Demonstration/shown how [ ]  Listening to audio/tapes [ ]  Looking at pics or video |
| **My Family, Caregivers, Siblings, Others** |
| First and last names | Age | Relationship to child | Where resides (primary or secondary home, outside of home) |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

 Insurance Information  |
| Primary Insurance: |  | ID Number: |  | Group #: |  |
| Policy Holder: |  | Employer: |  | Policy Holder DOB: |  |
| Secondary Insurance: |  | ID Number: |  | Group #: |  |
| Policy Holder: |  | Employer: |  | Policy Holder DOB: |  |
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| Medicaid Waiver: | Choose an item. | [ ]  Active [ ]  Wait List [ ]  Targeted [ ]  Applied | Application Date: |  |
| Case Management Co: |  | Case Manager: |  | Contact Info: |  |

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| **Educational Services** |
| **Current Services** |  |
| Type: | [ ]  First Steps [ ]  Head Start [ ]  Preschool [ ]  Homeschool [ ]  K-12: \_\_\_\_\_\_\_ [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| School Name: |  | School District: |   |
| Classroom Setting: |  | Eligibility Category: |  |
|  School Services: | [ ]  Individualized Education Plan (IEP)[ ]  504 Plan [ ]  Assistive Technology  | [ ]  Behavioral Intervention Plan (BIP) [ ]  Individual Health Plan (IHP)[ ]  Occupational Therapy [ ]  Physical Therapy [ ]  Speech Therapy[ ]  Developmental Therapy [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|
| Primary School Contact: | Name:  |  | [ ]  Classroom Teacher [ ]  Teacher of Record [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone:  |  | Fax:  |  | Email: |  |
|   Educational Hx Notes: |  |
| **Neuropsychology and Psychoeducational Testing**  |
|  Date: |  | Results: |  |
| **Childcare** |
|  Childcare type: | [ ]  Family Only [ ]  Paid In-home [ ]  Center-based [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Attendance: | [ ]  Full-time [ ]  Part-time [ ]  Respite only  |
|  Primary Contact: | Name: |  | [ ]  Classroom teacher [ ]  Director [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone:  |  | Email: |  |
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| **Notes/Other** |

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| Conditions and Medical History  |
| **Diagnosis** | **Diagnosis** |
| Birth/Genetic: |  | Cardiovascular: |  |
| Dental: |  | Endocrine: |  |
| Ears, Nose, and Throat: |  | Gastrointestinal: |  |
| Genitourinary: |  | Hematology: |  |
| Infectious Disease: |  | Musculoskeletal: |  |
| Neurologic: |  | Ophthalmology: |  |
| Psychological: |  | Renal: |  |
| Respiratory: |  | Skin: |  |
| Neurodevelopmental: |  | Behavioral: |  |
|

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| Health Care Team  |
| Primary Care Provider: |  | Phone: |  | Fax: |  |
| Primary CareCare Coordinator: |  | Phone: |  | Last Visit: |  | Next Visit: |  |
| Street Address: |  | City: |  | State: |  | Zip: |  |
| Preferred Hospital: |  | Phone: |  | Fax:  |  |
| **CARE TEAM** | **NAME/TYPE/LOCATION** | **LAST VISIT** | **FOLLOW UP VISIT** | **CONTACT INFORMATION** |
| Specialist 1: (diagnosis) |  |  |  |  |
| Specialist 2: |  |  |  |  |
| Specialist 3: |  |  |  |  |
| Specialist 4: |  |  |  |  |
| Specialist 5: |  |  |  |  |
| Specialist 6: |  |  |  |  |
| Psych / Behavior: |  |  |  |  |
| Dentist: |  |  |  |  |
| Vision: |  |  |  |  |
| Hearing: |  |  |  |  |
| Therapy (OT/PT/SLP): |  |  |  |  |

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| **Services**  |
| **Home & Community Services** |
| Home Care Provider: |  | Phone: |  |
| Community Agency Provider: |  | Phone: |  |
| Community Agency Provider: |  | Phone: |  |
| **Medical Equipment & Service Suppliers** |
| Child’s Medical Equipment & Supplies: |  |
| Vendor/service/contact: |  | Phone: |  |
| Vendor/service/contact: |  | Phone: |  |

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| Vital Signs |
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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |  | Weight: |  ( %)  | Height: |  ( %) | BMI: |  ( %) |
| HC: |  ( %) | Temp: |  | HR: |  | RR: |  |
| BP: |  | O2 Sat: |  | Notes: |  |

 |
| TREATMENTS |
| EMERGENCY PLAN: |
| MEDICATIONS – Prescriptions /Over the Counter /Complementary & Alternative  |
| Medication name  | Form | Dose | Times |  Comments: Purpose, Route, Special Instructions | Prescriber |
| **1.** |  |  |  |  |  |  |
| **2.** |  |  |  |  |  |  |
| **3.** |  |  |  |  |  |  |
| **4.** |  |  |  |  |  |  |
| **5.** |  |  |  |  |  |  |
| **6.** |  |  |  |  |  |  |
| **7.** |  |  |  |  |  |  |
| **8.** |  |  |  |  |  |  |
| **9.** |  |  |  |  |  |  |
| **10.** |  |  |  |  |  |  |
| **\*Please always verify current medications and dosing before treating.** |
| **Date Medication List Last Verified:** |
| Special Instructions: |  |
| Medication Allergies/Contraindications: |  | Medication History: |  |
| Preferred Pharmacy: |  | Phone:  |  | Fax: |  |
| **Other Treatments** |
| Diet: |  |
| Other: |  |
| Safety Concerns/Needs: |  |
| **Immunizations** |
| *(insert CHIRP record here)*

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| **Notes/Other** |

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| **Family History** |
| **Condition** | **Who?** | **Condition** | **Who?** | **Condition** | **Who?** |
| Heart Disease: |  | Hypertension: |  | Diabetes: |  |
| Mental Health: |  | Cancer Type: |  | Genetic: |  |
| Neurodevelopmental: |  | Lipids: |  | Other**:**  |  |

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| **Hospitalizations** |
|  |
| Surgeries  |
|  |
| Procedures |
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| Labs  |
|  |

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**\* Negotiated Actions\***

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| **Prioritized Goals** | **Action Items/strategies****(To reach short term goals)**  | **Person responsible** | **Status** |
|  | **Family Identified Needs and Goals** |   |   |
|  |   |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  | **Comprehensive Care Coordination** **Child/Family Snapshot (goals, resources, actions)** |  |  |
| Government Services/Healthcare Financing |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Family Support/Needs |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Education/School |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Socialization/Community |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Transportation |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Transition (ages 12 and older) |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  | **Clinical Care Coordination****Child Snapshot, Needs and Goals** |  |  |
|  |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
|  |  |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |
| Family-centered, integrated, continuous care  | Provide *Shared Plan of Care* to family’s identified services to: * + Facilitate communication between everyone involved
	+ Promote continuity of care
	+ Enhance collaboration
 |  | [ ] Prioritized [ ] In Progress[ ] On Hold [ ] Completed |

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|  **Future Goals** |

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|  **Personal Family Information**  |
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| --- | --- |
| Race/Ethnicity: | [ ]  Black [ ]  White [ ]  Hispanic [ ]  Native American [ ]  Other:  |

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| Family Concerns: |  |
| Recent Stressors: |  |
| Caregivers’Education/Occupation: |  |
| Family Health Care Coverage: |  |
| Living Arrangements: |  |
| Family’s Support System: |  |
| Backup Trained Caregivers: |  |
| Income: |

|  |
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| [ ]  SSI/SSDI (Supplemental Security Income/Social Security Disability) \_\_\_\_\_\_\_/mo |
| [ ]  Adoption Assistance \_\_\_\_\_\_\_/mo  |

[ ]  TANF (Temporary Assistance for Needy Families) \_\_\_\_\_\_\_\_ (amount/date)[ ]  Child Support \_\_\_\_\_\_\_/mo[ ]  Other:  |
| Housing/Environment: | [ ]  Own [ ]  Rent [ ]  Other:  |
| Utilities: |  |
| Food: |

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| [ ]  WIC (Women, Infants and Children) Nutrition Program |
| [ ]  SNAP (Supplemental Nutrition Assistance Program) |

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| Legal: |  |
| Education/Childcare Issues: | Funding for Childcare: [ ]  Voucher supported [ ]  Private Pay [ ]  Other: |
| Future Financial Planning: |  |
| Culture/Ethnicity/Beliefs: |  |
| Risk/Safety Concerns: |  |
| Health Teaching Information Needs: |  |
| Confidential Family History: |  |
| Other: |  |