**Shared Plan of Care**

**\*Medical Summary\***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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) | |  | |  |  |  | |  | |  |  |  | |  | |  |  |  | |  | |  |  |  |  Insurance Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance: | |  | | | | | | | | | | | | | | ID Number: | | | | | |  | | | | | | | | | | | Group #: | | | |  | | |
| Policy Holder: | |  | | | | | | Employer: | | |  | | | | | | | | | | | | | | | | | Policy Holder DOB: | | | | | | | | |  | | |
| Secondary Insurance: | |  | | | | | | | | | | | | | | ID Number: | | | | | |  | | | | | | | | | | | Group #: | | | |  | | |
| Policy Holder: | |  | | | | | | Employer: | | |  | | | | | | | | | | | | | | | | | Policy Holder DOB: | | | | | | | | |  | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Medicaid Waiver: | Choose an item. | | Active  Wait List  Targeted  Applied | | | | Application Date: | |  | | Case Management Co: | |  | | Case Manager: |  | Contact Info: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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: | |  | | | | | | | |  | | --- | | **Notes/Other** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | | | |  | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Health Care Team | | | | | | | | | | | | | | | | | | | | | | | | | | Primary Care Provider: |  | | | | | Phone: | |  | | | | | | | | Fax: | |  | | | | | | | | Primary Care  Care 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): | |  | | | | | | | | |  | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **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: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vital Signs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 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)*   |  |  | | --- | --- | | |  | | --- | | **Notes/Other** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Family History** | | | | | | | **Condition** | **Who?** | **Condition** | **Who?** | **Condition** | **Who?** | | Heart Disease: |  | Hypertension: |  | Diabetes: |  | | Mental Health: |  | Cancer Type: |  | Genetic: |  | | Neurodevelopmental: |  | Lipids: |  | Other**:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hospitalizations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surgeries | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procedures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  | | --- | | Labs | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**\* Negotiated Actions\***

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |

|  |
| --- |
| **Future Goals** |

|  |  |
| --- | --- |
| **Personal Family Information** | |
| |  |  | | --- | --- | | Race/Ethnicity: | Black  White  Hispanic  Native American  Other: | | |
| Family Concerns: |  |
| Recent Stressors: |  |
| Caregivers’  Education/Occupation: |  |
| Family Health Care Coverage: |  |
| Living Arrangements: |  |
| Family’s Support System: |  |
| Backup Trained Caregivers: |  |
| Income: | |  | | --- | | 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: | |  | | --- | | WIC (Women, Infants and Children) Nutrition Program | | SNAP (Supplemental Nutrition Assistance Program) | |
| 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: |  |