

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Patient Information

Name: _____ DOB: _____

Male Female

Address: _____ Race/Ethnicity

City/State/Zip: _____ African American Caucasian

Phone: _____ Fax: _____ American Indian Hispanic

Email: _____ Asian Other

Emergency Contact: _____

Communication Preference: Phone _____ Fax _____

Email _____ Mail Other _____

Decision Maker: _____ Relationship: _____

Legal Status: Guardian Health Care Representative Power of Attorney

Informal Rep Minor Child

Primary Caregiver: _____ Relationship: _____

Contact information: _____
(if other than above) _____

Health Insurance Plan: Primary _____

ID No: _____ Anticipate change: _____

Secondary _____

ID No: _____ Anticipate change: _____

Waiver Type: _____ Waiting List: _____

Patient Says "What you should know about my child and family is (i.e., How does your child communicate?): _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Diagnoses

1. _____ ICD9 _____
2. _____ ICD9 _____
3. _____ ICD9 _____
4. _____ ICD9 _____
5. _____ ICD9 _____
6. _____ ICD9 _____
7. _____ ICD9 _____
8. _____ ICD9 _____

Medical and Service Providers

Health Care Providers

Primary Care: _____ Peds Adult; Plan for change:

Contact Information: _____

Specialists:

- _____ Peds Adult Phone: _____ release
- _____ Peds Adult Phone: _____ release
- _____ Peds Adult Phone: _____ release
- _____ Peds Adult Phone: _____ release
- _____ Peds Adult Phone: _____ release
- Dental: _____ Peds Adult Phone: _____ release
- Vision: _____ Peds Adult Phone: _____ release
- Hearing: _____ Peds Adult Phone: _____ release
- Psych/Behavior: _____ Peds Adult Phone: _____ release

Service Providers

- Physical Therapy Contact: _____ Phone: _____ release
- Occupational Therapy Contact: _____ Phone: _____ release
- Speech Therapy Contact: _____ Phone: _____ release
- Early Intervention Contact: _____ Phone: _____ release
- School Contact: _____ Phone: _____ release

Service Providers

Other: _____ Phone: _____ release

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Medical History

Past History Summary

Neurologic-	Cardiovascular-
Respiratory-	Gastrointestinal-
Genourinary-	Renal-
Endocrine-	Infectious Disease-
Rheum/Musculoskeletal-	Heme-
Skin-	Ear Nose Throat-
Ophthal-	Dental-
Psych-	Behavior-

Comments: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Medications *also include over the counter medications*

Name	Dosage	Period Taken	Purpose
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Immunizations and Dates:

DtaP	1. __ 2. __ 3. __ 4. __ 5. __	Reactions: _____
DT	1. __ 2. __	Reactions: _____
Polio	1. __ 2. __ 3. __ 4. __	Reactions: _____
HIB	1. __ 2. __ 3. __ 4. __	Reactions: _____
Pevnar	1. __ 2. __ 3. __ 4. __	Reactions: _____
MMR	1. __ 2. __	Reactions: _____
Varicella	1. __ Booster _____	Reactions: _____
HBV	1. __ 2. __ 3. __	Reactions: _____
TB _____	Reactions: _____	
Flu _____	Reactions: _____	

Other:

Vaccinations that Were Not Administered:

Allergies: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Home Care Equipment:

Company Name A/contact: _____ Phone: _____

Company Name B/contact: _____ Phone: _____

Company Name C/contact: _____ Phone: _____

- O2 (stationary portable)
- Apnea monitor
- Suction machine/supplies
- Feeding pump/supplies
- N/G tube
- Wheelchair
- BP monitor
- Pulse oximeter (SAT)
- Trach tube, Type/Size: _____ Cuff: Yes No
- Vent (Settings: _____)
- Formula: _____
- GT/GJ (Type: _____ size: _____)
- Car seat
- IV/TPN (Rx: _____)

Other _____

Family History:

Maternal:

- unknown
- Cancer Heart Disease
- Diabetes Stroke
- Birth defects
- Mental retardation/learning disabilities
- Abnormal growth patterns
- Other: _____

Paternal:

- unknown
- Cancer Heart disease
- Diabetes Stroke
- Birth defects
- Mental retardation/learning disabilities
- Abnormal growth patterns
- Other: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Social History, Financial & Legal Information

Social History

Family Unit: _____

Individuals residing in home: _____

Caregiver concerns: _____

Source/frequency of respite from each other: _____

Home access: _____ Own Rent

Education/Employment

Education: Level: _____ School/District: _____ Contact: _____

Adaptive educational services: _____ IEP Other

Employer: _____ Contact: _____

Support services: _____ Contact: _____

Previous experience/volunteer: _____

Recreation/Social Activities:

Hobbies/interests: _____

Circle of friends: _____

Religion/Organization/Clubs: _____ Congregation: _____

Self-perceived strengths: _____

Legal/Financial

Independent Dependent, Contact: _____

Financial Source: _____

Transition

Future living goals: _____

Future self-care goals: _____

Future education goal: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Future employment goals: _____

Future recreation/social goals: _____

Future legal goals: _____

Future financial goals: _____

Functional Assessment:

	Independe nt	Assistanc e	Dependent	Comments
Activities of Daily Living				
Telephone				
Transportation				
Shopping				
Meal prep				
Housework				
Managing money				
Bathing				
Dressing				
Toileting				
Transfer				
Feeding				
Health Care Self-Management				
Taking medicines				
Refilling medicines				
Managing health insurance issues				
Recognizing signs of illness				
Making doctor's appt.				
Understanding medical conditions				
Making health care decisions				

Future self-care goal: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Community Resources:

Care Coordinator: _____ Phone: _____

- Medicaid Waiver Program Child Care Assistance Travel/Transportation Assistance
 Food Stamps Housing Assistance SSI WIC

Medicaid Caseworker: _____ Phone: _____

Other: _____

Connection with the local "disease specific" community based organization; support groups _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Physician Updates

Physician: _____ Date of contact: _____

Means of contact: In office Hospital consult Phone consult Other: _____

Reason for contact: _____

Updates to diagnoses: No Yes: _____

Updates to medications: No Yes: _____

Tests Ordered: No Yes: _____

Test Results: _____

Recommendations: _____

Physician: _____ Date of contact: _____

Means of contact: In office Hospital consult Phone consult Other: _____

Reason for contact: _____

Updates to diagnoses: No Yes: _____

Updates to medications: No Yes: _____

Tests Ordered: No Yes: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Test Results: _____

Recommendations: _____

Physician: _____ Date of contact: _____
Means of contact: In office Hospital consult Phone consult Other: _____
Reason for contact: _____
Updates to diagnoses: No Yes: _____

Updates to medications: No Yes: _____

Tests Ordered: No Yes: _____

Test Results: _____

Recommendations: _____

Physician: _____ Date of contact: _____
Means of contact: In office Hospital consult Phone consult Other: _____
Reason for contact: _____
Updates to diagnoses: No Yes: _____

Updates to medications: No Yes: _____

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Tests Ordered:	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____

Test Results:	_____		

Recommendations:	_____		

Physician:	_____	Date of contact:	_____
Means of contact:	<input type="checkbox"/> In office	<input type="checkbox"/> Hospital consult	<input type="checkbox"/> Phone consult <input type="checkbox"/> Other: _____
Reason for contact:	_____		
Updates to diagnoses:	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____

Updates to medications:	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____

Tests Ordered:	<input type="checkbox"/> No	<input type="checkbox"/> Yes:	_____

Test Results:	_____		

Recommendations:	_____		

DRAFT – Medical Care Coordination Document

Revised 9-11-08

Physician: _____	Date of contact: _____
Means of contact: <input type="checkbox"/> In office <input type="checkbox"/> Hospital consult <input type="checkbox"/> Phone consult <input type="checkbox"/> Other: _____	
Reason for contact: _____	
Updates to diagnoses: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	

Updates to medications: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	

Tests Ordered: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	

Test Results: _____	

Recommendations: _____	

Notes from Parent Telemeeting in August:

- Make available on flash drives, on the web, or electronically
- These are recommendations, take what's there and fit your needs
- Like having a universal form that can be changed to fit our needs
- The form could go on the Region 4 website then have a "print a copy link" as well
- Health Insurance Plan section "waiver type" – What does that mean? Each state has so many different waivers, it needs to go separately (for example, Kentucky got a new waiver)