

Medical Care Coordination Plan

Patient Information

Name: _____ DOB: _____

Female Male

Race/Ethnicity identified with:

Phone: _____

Hispanic or Latino

Fax: _____

Black or African American

Email: _____

White or Caucasian

Address: _____

American Indian or Alaskan Native

Asian/Southeast Asian or Pacific Islander

City: _____

Arab or Middle Eastern American

Multi-racial

State: _____ Zip Code: _____

Other: _____

Parent/Guardian Name: _____

Relationship: Custodial Parent(s) Guardian Health Care Representative

Minor Child Power of Attorney Informal Representative

Contact Information:

(if other than above): _____

Communication Preference: Phone Email Fax US Mail Other: _____

Primary Caregiver: _____ Relationship: _____

(if other than above)

Contact Information: _____

(if other than above): _____

Communication Preference: Phone Email Fax US Mail Other: _____

Additional Important Contacts

Emergency Contact: _____ Relationship: _____

Contact Information: _____

Communication Preference: Phone Email Fax US Mail Other: _____

Decision Maker: _____ Relationship: _____

& Contact Information: _____

(If other than primary)

caregiver)

Care Coordinator: _____ Phone: _____
Clinic/Office: _____ Email: _____
Medicaid caseworker: _____ Phone: _____
Other: _____

Health Insurance & Medical Assistance Benefits

Primary: _____ Phone: _____
ID #: _____ Anticipate change: _____
Secondary: _____ Phone: _____
ID #: _____ Anticipate change: _____
Next: _____ Phone: _____
ID# _____ Anticipate change: _____
Next: _____ Phone: _____
ID #: _____ Anticipate change: _____
Waiver Type: _____ Waiting list: _____

Home Care Equipment

Company A Name/Contact: _____ Phone: _____
Company B Name/Contact: _____ Phone: _____
Company C Name/Contact: _____ Phone: _____
 Oxygen; if checked also indicate: Stationary Portable
 Pulse Oximeter (SAT)
 BP Monitor Cuff: Yes No
 Wheelchair
 Car seat
 Trach Tube, Type/Size: _____
 Suction machine/supplies Vent, settings: _____
 Feeding pump/supplies Formula: _____
 GT/GJ, Type: _____ Size: _____
 Apnea monitor

- N/G Tube
- IV/TPN; RX: _____
- Other, specify: _____

Functional Assessment					
Activities of Daily Living (ADL)	Independent	With Assistance	Dependent	Not Age applicable	Comments
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care Self-Management	Independent	With Assistance	Dependent	Not Age applicable	Comments
Taking medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizing signs of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Making doctor's appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Refilling medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing health insurance issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Making health care decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Goals	What do you want for your child?	What are your child's goals?
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Life Domain	Parent Goal	Child Goal/Desires
Self-care		
Medical/ Treatment		
Education		
Recreational		
Spiritual/ Religious		
Employment		
Financial		
Transition to adult Services		
Future living		
Legal		

Diagnoses

1. _____ Age at DX: _____ ICD9 _____
2. _____ Age at DX: _____ ICD9 _____
3. _____ Age at DX: _____ ICD9 _____

4.	_____	Age at DX: _____	ICD9 _____
5.	_____	Age at DX: _____	ICD9 _____
6.	_____	Age at DX: _____	ICD9 _____
7.	_____	Age at DX: _____	ICD9 _____
8.	_____	Age at DX: _____	ICD9 _____

Medical, Healthcare and Service Providers

Primary Care: _____ Peds Adult

Contact Information: _____

Specialists *(please list all that apply – Name & Specialty)*

_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
_____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
Psych/Behavioral: _____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
Dental: _____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
Vision: _____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
Hearing: _____	<input type="checkbox"/> Peds	<input type="checkbox"/> Adult	Phone: _____	<input type="checkbox"/> release
Physical Therapy: _____			Phone: _____	<input type="checkbox"/> release

Occupational Therapy:	_____	Phone: _____	<input type="checkbox"/> release
Speech Therapy:	_____	Phone: _____	<input type="checkbox"/> release
Early Intervention:	_____	Phone: _____	<input type="checkbox"/> release
School contact:	_____	Phone: _____	<input type="checkbox"/> release
Other, specify:	_____	Phone: _____	<input type="checkbox"/> release
Other, specify:	_____	Phone: _____	<input type="checkbox"/> release

Medications, Foods and Formulas, *also include over the counter medications*

** Please continue on additional page, if necessary*

	Name	Dosage	Period Taken	Purpose
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

12.				
13.				
14.				
15.				

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Allergies/Allergic Reactions	
Allergies:	Reaction

Medical History

Patient has an Emergency Plan No Yes If yes, check if plan is attached

If yes, Responsible physician: _____

Patient has a medical home Care Plan No Yes

If yes, responsible person
& Clinic

Neurological:	
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Cardiovascular:	
Respiratory:	
Gastrointestinal:	
Genourinary:	
Renal:	
Infectious Disease:	
Endocrine:	
Heme:	
Rheum/ Musculoskeletal:	
Ear, Nose & Throat	
Skin	
Dental	

Ophthalmologic:	
Behavioral	
Psychiatric	
Other, Specify	

Family History	
Maternal	Paternal
<input type="checkbox"/> Unknown _____	<input type="checkbox"/> Unknown _____
<input type="checkbox"/> Birth Defects _____	<input type="checkbox"/> Birth Defects _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Mental Retardation/ Learning Disabilities _____	<input type="checkbox"/> Mental Retardation/ Learning Disabilities _____
<input type="checkbox"/> Abnormal Growth Patterns _____	<input type="checkbox"/> Abnormal Growth Patterns _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
Sibling 1	Sibling 2
<input type="checkbox"/> Unknown _____	<input type="checkbox"/> Unknown _____
<input type="checkbox"/> Birth Defects _____	<input type="checkbox"/> Birth Defects _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Mental Retardation/ Learning Disabilities _____	<input type="checkbox"/> Mental Retardation/ Learning Disabilities _____

Learning Disabilities _____ <input type="checkbox"/> Abnormal Growth Patterns _____ <input type="checkbox"/> Other	Learning Disabilities _____ <input type="checkbox"/> Abnormal Growth Patterns _____ <input type="checkbox"/> Other
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Immunizations and Dates:

Responsible Provider: _____

DtaP	1	_____	2	_____	3	_____	4	_____	5	_____	Reactions: _____
DT	1	_____	2	_____							Reactions: _____
Polio	1	_____	2	_____	3	_____	4	_____			Reactions: _____
HIB	1	_____	2	_____	3	_____	4	_____			Reactions: _____
Prevnar	1	_____	2	_____	3	_____	4	_____			Reactions: _____

Immunizations, continued

MMR	1	_____	2	_____		Reactions: _____	
HBV	1	_____	2	_____	3	_____	Reactions: _____
Varicella	1	_____	Booster	_____		Reactions: _____	
TB		_____				Reactions: _____	
Flu		_____				Reactions: _____	
Other, specify:		_____				Reactions: _____	
		_____				Reactions: _____	
		_____				Reactions: _____	
		_____				Reactions: _____	

Vaccinations that were NOT Administered & Reason

Vaccine	Reason for not administering

Additional Family Information

What you should know about me/my child and family is: _____

Connection with local "disease specific" community-based organizations/support groups: _____

Comments/Notes: _____

Healthcare Provider Update

Provider:

Date of Contact:

Means of Contact: In Office Hospital Consult Phone Consult

Other, specify:

Reason for contact:

Updates to diagnoses: No Yes;

Updates to medications: No Yes;

Tests ordered No Yes;

Test Results:

Recommendations:

Healthcare Provider Update

Provider:

Date of Contact:

Means of Contact: In Office Hospital Consult Phone Consult

Other, specify:

Reason for contact:

Updates to diagnoses: No Yes;

Updates to medications: No Yes;

Tests ordered No Yes;

Test Results:

Recommendations:

Healthcare Provider Update

Provider: _____ Date of Contact: _____

Means of Contact: In Office Hospital Consult Phone Consult
 Other, specify: _____

Reason for contact:

Updates to diagnoses: No Yes;
Updates to medications: No Yes;
Tests ordered No Yes;

Test Results: _____

Recommendations: _____

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Provider: _____ Date of Contact: _____

Means of Contact: In Office Hospital Consult Phone Consult
 Other, specify: _____

Reason for contact:

Updates to diagnoses: No Yes:
Updates to medications: No Yes:
Tests ordered No Yes:

Test Results: _____

Recommendations: _____

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Means of Contact: In Office Hospital Consult Phone Consult
 Other, specify: _____

Reason for contact:

Updates to diagnoses: No Yes;
Updates to medications: No Yes;
Tests ordered No Yes;

Test Results: _____

Recommendations:

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 Other, specify: _____

Reason for contact:

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 Other, specify: _____

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Test Results:

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Test Results:

Recommendations:

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Tests ordered No Yes;

Test Results:

Recommendations:

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Test Results: _____

Recommendations: _____

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Reason for contact:

Updates to diagnoses: No Yes;

Updates to medications: No Yes;

Tests ordered No Yes;

Test Results: _____

Recommendations:

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Date of Contact:

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Recommendations:

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Date of Contact:

Means of Contact: In Office Hospital Consult Phone Consult
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Reason for contact:

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Test Results:

Recommendations: