

# 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

City: \_\_\_\_\_  Asian/Southeast Asian or Pacific Islander

State/Zip \_\_\_\_\_  Arab or Middle Eastern American

: \_\_\_\_\_  Multi-racial

\_\_\_\_\_  Other: \_\_\_\_\_

Legal Status:     Custodial Parent       Guardian       Health Care Representative

Minor Child       Power of Attorney       Informal Representative

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

\_\_\_\_\_

## Important Contacts

Emergency Contact: \_\_\_\_\_

Communication Preference:     Phone     Email     Fax     US Mail     Other: \_\_\_\_\_

Primary Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Information: \_\_\_\_\_

(If other than above) \_\_\_\_\_

Decision Maker: \_\_\_\_\_ Relationship: \_\_\_\_\_

(If other than primary caregiver)      Contact info: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/Office: \_\_\_\_\_ Email: \_\_\_\_\_

Medicaid caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_

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

<b>Functional Assessment</b>				
<b>Activities of Daily Living</b>	<b>Inde- pendent</b>	<b>With Assistance</b>	<b>Depen- dent</b>	<b>Comments</b>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Health Care Self- Management</b>	<b>Inde- pendent</b>	<b>With Assistance</b>	<b>Depen- dent</b>	<b>Comments</b>
Taking medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Refilling medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing health insurance issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizing signs of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Making doctor's appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Making health care decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Patient Goals**

Future living goals:



**Patient Goals, continued**

Self-care goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Education goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employment goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Financial goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical/Treatment goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Transition to Adult Services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family History

Maternal	Paternal
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Birth Defects
<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, specify: _____	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke

## Home Care Equipment

Company Name A/Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Company Name B/Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Company Name C/Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Oxygen  
( Stationary  Portable)

Pulse Oximeter (SAT)

BP Monitor  
Cuff:  Yes  No

Wheelchair

Car seat

Apnea monitor

Trach Tube, Type/Size: \_\_\_\_\_

Suction machine/supplies

Vent, settings: \_\_\_\_\_

Feeding pump/supplies

Formula: \_\_\_\_\_

GT/GJ, Type: \_\_\_\_\_ Size: \_\_\_\_\_

IV/TPN; RX: \_\_\_\_\_  N/G Tube

Other, specify: \_\_\_\_\_

## Health Insurance

Primary: \_\_\_\_\_

ID No.: \_\_\_\_\_ Anticipate Change: \_\_\_\_\_

Secondary: \_\_\_\_\_

ID No.: \_\_\_\_\_ Anticipate Change: \_\_\_\_\_

Waiver \_\_\_\_\_ Waiting List: \_\_\_\_\_

Type: \_\_\_\_\_

### Diagnoses

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

### Medical, Healthcare and Service Providers

Primary Care: \_\_\_\_\_  Peds  Adult

Contact Information: \_\_\_\_\_

Specialists *(please list all that apply)*

_____	<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
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
Psych/Behavioral: _____	<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

**Medications, Foods and Formulas, *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: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Medical History**

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

Responsible physician: \_\_\_\_\_

Patient has a medical home Care Plan  No  Yes

If yes, responsible clinic or person

**Medical History, continued**

Neurological: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cardiovascular: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respiratory: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Gastrointestinal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Genourinary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Renal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Infectious  
Disease: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History, continued**

Endocrine: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Heme: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respiratory: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respiratory: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rheum/Musculoskeletal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ear/Nose/Throat: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Skin: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History, continued**

Dental: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respiratory: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ophthalmologic: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

**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:	_____
	_____	_____	_____	_____			

Prevna 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ Reactions: \_\_\_\_\_  
r

### 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

### Healthcare Provider Tracking

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: \_\_\_\_\_

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: \_\_\_\_\_  
Updates to diagnoses:  No  Yes; \_\_\_\_\_  
Updates to medications:  No  Yes; \_\_\_\_\_  
Tests ordered  No  Yes; \_\_\_\_\_  
Test Results: \_\_\_\_\_  
Recommendations: \_\_\_\_\_

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 Other, specify: \_\_\_\_\_  
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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: \_\_\_\_\_  
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: \_\_\_\_\_  
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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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:

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Test Results:

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Recommendations:

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