Boston Children's at Martha Eliot Health Center
Until every child is well™

Patient Label

Patient-Centered Medical Plan of Care

The Patient-Centered Medical Plan of Care is completed yearly at the annual physical exam and revised as indicated.

Demographic Information

Patient Name

Who has custody of the child? ☐ Mother ☐ Father ☐ Guardian ☐ Foster Parent ☐ Other

Date of Birth

Confidential Phone # (Adolescents)

Parent/Guardian Name

Address

Phone Number

Alternate Phone Number

Email Address

Parent/Guardian Name

Address

Phone Number

Alternate Phone Number

Email Address

Emergency Contact

Phone Number

Relationship

Emergency Contact

Phone Number

Relationship

Primary Language of Patient

Interpreter Needed? ☐

Primary Language of Parent/Guardian

Interpreter Needed? ☐

Primary Insurance

Insurance ID Number

Subscriber Name

Secondary Insurance

Insurance ID Number

Subscriber Name

Provider Information

Name	Specialty	Hospital/Facility	Phone	Fax	Email

Patient Label

Medical Information

Allergies/Reactions

Active Medications

See attached *Visit Summary*

Pharmacy

Name	Address	Phone	Fax

Problem List

Date	Problem

Procedures/Surgeries

Date	Procedure

Recent Diagnostic Testing (EKG, Swallow Study, etc.)

Date	Test/Study

Well-Care Last Physical Exam

Date	Height	Weight	HC	BMI/%	Vision	Hearing

Well-Care Last Physical Exam Vital Signs

Date	HR	RR	BP/Cuff Size	Oxygen Saturation	Oxygen Delivery Rate

Emergency Orders - Call 911 (Written when a chronic condition has the potential to result in a medical emergency)

Date	Condition	Instructions

Supportive Care - Identified Needs for Activities of Daily Living

- ☐ Nutrition
- ☐ Communication
- ☐ Fine Motor
- ☐ Sleep
- ☐ Gross Motor & Mobility
- ☐ Relating to Others
- ☐ Toileting
- ☐ Hygiene & Self-Care

Durable Medical Equipment

Date	Item	Order	Supply Company/Contact Person	Phone	Fax

Communication Devices and Adaptive Equipment

Item	Order	Rehabilitative Service Provider	Vendor/Contact Person	Phone	Fax

Transportation Services in Place

- ☐ MBTA The RIDE
- ☐ School Transportation
- ☐ Modified Vehicle
- ☐ RMV Disabled Placard/Plate
- ☐ Transportation Needs (Please Specify)

- ☐ Prescription for Transportation (PT-1)

Please call transportation company at least three days before scheduled appointment.

Company Name

Phone

Specialist/Location

Expiration Date

Community/School Based Service Providers

Agency/School	Contact	Service	Phone	Fax	Email

Patient Label

About Me (Patient Preferences, Needs, and Values)

Completed/Answered by the Patient/Family

I prefer to be called

My preferred spoken language is

I live with

Sometimes I need help understanding written information about my health.

☐ Yes
☐ No

I believe the following people in my life are supportive of my health care goals:

Shared Goal Setting

These are goals that you and/or your provider identify as a priority for the next year to improve you health and quality of life.

Date	Goal	Target Date	Plan/Action Steps	Date Achieved/ Revised

My Success

I have accomplished my goals and below I explain how I did it.

Date	My Success	Strategies Used for Success

Patient Label

Action Plan

Referral/Action	Hospital/Service	Phone/Fax	Date Referred	Person Responsible/Notes

Notes

Signature of Staff Completing Form: _____ **Date:**_____

Date	Staff Signature	Print Name	Initials

Attached are the Following Documents:

Visit Summary & School Physical Exam Form/Immunizations