Last review and updates:
*Medical Summary – XX/XX/XXXX *(Please note: Medical summary may not be entirely complete before or after updates)*
*Goals and Negotiated Actions - XX/XX/XXXX

Shared Plan of Care

SEE ATTACHED EMERGENCY TREATMENT PLAN(S)*as noted

☐ Asthma Action Plan ☐ Seizure Action Plan ☐ Home Health Plan ☐ Advanced Directive ☐ Other:_____

ABOUT ME

First Name:	Last name:	Middle:	Sex:	Birthdate:	Age:	Medical Record Number (system) **(IU Health)**

{Attach Photo Here}

My family wants you to know:
-
-

My preferences include:
-
-

Helpful tips/behavioral triggers:
-
-

Primary Neurodevelopmental diagnosis:	

Areas of Difficulty (check all that apply)

☐ Behavioral	☐ Mobility	☐ Diet	☐ Vision	☐ Sleep
☐ Learning	☐ Orthopedic/Musculoskeletal	☐ Feeding/Swallowing	☐ Sensory Processing	☐ Maintaining Safety
☐ Communication	☐ Respiratory	☐ Hearing	☐ Stamina/Fatigue	☐ Other_____

Area of Development	Strengths	Challenges
Activities of Daily Living		
Communication		
Behavior/Safety		
Function/Mobility/Sensory		
Other		
Care Coordination Clinical Observation - Child Snapshot:	*(Clinician Name, date)*	

MY FAMILY

Caregiver Information

First Name:	Last name:	Relationship to Patient:

Street Address:	City:	County:	State:	Zip:

Street Address:	City:	State:	Zip:

Email (Preferred? ☐ Y ☐ N):	Phone (Preferred? ☐ Y ☐ N):	Secondary Phone (Preferred? ☐ Y ☐ N):

Legal Decision Maker:	Emergency Contact:

Living in My Home(s)

Primary			Secondary		
First and last name	Age	Relationship to child	First and last name	Age	Relationship to child

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Other Things to Know

Preferred Language:	
Race/Ethnicity:	
Support network:	
Life stressors/concerns:	
Housing:	☐ Own ☐ Rent ☐ Other:
Transportation access:	
Home internet access:	☐ Yes ☐ *check here if phone/mobile access only)* ☐ No ☐ *Ability to print at home*
Caregivers' occupations:	
Caregivers' learning preferences:	(who)_____ ☐ reading ☐ spoken info/instruction ☐ demonstration/shown how ☐ listening to audio/tapes ☐ looking at pictures or video (who)_____ ☐ reading ☐ spoken info/instruction ☐ demonstration/shown how ☐ listening to audio/tapes ☐ looking at pictures or video

INSURANCE INFORMATION

Primary		Secondary	
Insurer:		Insurer:	
ID Number:		ID Number:	
Group #:		Group #:	
Policy holder:		Policy holder:	
Employer:		Employer:	
Policy Holder DOB:		Policy Holder DOB:	

SERVICES & PROGRAMS

Government & Social Services

☐ WIC (Women, Infants and Children) Nutrition Program
☐ Food Stamps
☐ TANF (Temporary Assistance for Needy Families)
☐ Other: _____
☐ SSI (Social Security Income)
☐ SSDI (Social Security Disability Insurance)
☐ CCDF (Child Care Development Fund)
☐ Other: _____

Indiana Medicaid Waiver Program

Waiver Name:		Primary Contact:	Name:	
Date Applied:			Company:	
Current Status:	☐ Applied ☐ Wait List ☐ Targeted ☐ Active		Phone:	
			Email:	

School Program & Services

Current Services				Previous Services	
Type:	☐ First Steps ☐ Head Start ☐ Preschool ☐ K-12: _____ ☐ Homeschool ☐ Other: _____			Type:	☐ First Steps ☐ Head Start ☐ Preschool ☐ Homeschool ☐ K-12: ___ ☐ Other: _____
School name:		School District:		School name:	
Classroom Setting:		Eligibility Category:		School District:	

Services:	☐ Individualized Education Plan (IEP) ☐ Response to intervention (RTI) ☐ Behavioral Intervention Plan (BIP) ☐ Special transportation ☐ Orientation & Mobility (O&M) ☐ Augmentative Communication ☐ Assistive Technology ☐ Gifted services	☐ Speech/language therapy ☐ Physical therapy (PT) ☐ Occupational therapy (OT) ☐ Vision Services ☐ 504 Plan ☐ Individual Family Support Plan (IFSP) ☐ Other: _____ ☐ Other: _____

Primary Contact:	Name:		☐ Classroom teacher ☐ Teacher of Record ☐ Other:
	Phone:		
	Fax:		
	Email:		

Educational History Notes:
•

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Childcare				
Name:		Primary Contact:	Name:	
Type:	☐ In-home ☐ Center-based ☐ Other:			☐ Classroom teacher ☐ Director ☐ Other:
Attendance:	☐ Full-time ☐ Part-time ☐ Respite only		Phone:	
Funding:	☐ Voucher supported ☐ Private Pay ☐ Other:		Email:	

NOTES/ADDITIONAL INFO

Last review and updates:
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*Goals and Negotiated Actions - XX/XX/XXXX

Medical Summary

PRIMARY CARE			
Provider Name:	Area of Practice:	Phone:	Fax:
Practice Name (Health Network):		Non-clinician contact:	Phone:
Street Address:	City:	State:	Zip:

CONDITIONS					
System or Area	**Diagnoses**	**Date**	**System or Area**	**Diagnoses**	**Date**
Birth/Genetic:			Cardiovascular:		
Dental:			Endocrine:		
Ears, Nose, and Throat:			Gastrointestinal:		
Genitourinary:			Hematology:		
Infectious Disease:			Musculoskeletal:		
Neurologic:			Ophthalmology:		
Psychiatric/Psychological:			Renal:		
Respiratory:			Skin:		
Neurodevelopmental:			Behavioral:		

SPECIALTY CARE & OTHER MEDICAL PROVIDERS					
Name/Specialty		**Status**	**Last Visit**	**Reason for Service**	**Contact Information**
Referral Source for Care Coordination:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 1:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 2:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 3:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 4:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 5:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Specialty 6:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Psych / Behavior:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Dentist:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Vision:		☐ Ongoing ☐ As needed ☐ Not seeing again			

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Hearing:		☐ Ongoing ☐ As needed ☐ Not seeing again			
Therapy (OT/PT/etc.):		☐ Ongoing ☐ As needed ☐ Not seeing again			
Therapy (OT/PT/etc.):		☐ Ongoing ☐ As needed ☐ Not seeing again			
Therapy (OT/PT/etc.):		☐ Ongoing ☐ As needed ☐ Not seeing again			
Home Care:		☐ Ongoing ☐ As needed ☐ Not seeing again			

MEDICATIONS & TREATMENT

As reported by XX on XX/XX/XXXX

MEDICATION ALLERGIES:

Prescription Medication Name	Form	Dose	Time of day	Reason/Prescriber	Route / Other Comments:

Over-the-Counter Medication Name	Form	Dose	Time of day	Reason/Prescriber	Route / Other comments:

Special Instructions:					
Medication History:					
Medical Contraindications:					
Preferred Pharmacy:		Phone:		Fax:	
Preferred Hospital:		Phone:		Fax:	

EQUIPMENT & SUPPLIES

Medical Equipment & Supplies :

☐ Tracheostomy
☐ Suction
☐ Nebulizer
☐ Oxygen
☐ Monitors:
__apnea __O2__cardiac __glucose
☐ Feeding Tube
☐ Feeding pump
☐ Enteral Formula
☐ Incontinence Supplies
☐ Other_____
☐ Other_____

Assistive Technology & Devices:

☐ Communication Device
☐ Adaptive Seating
☐ Wheelchair
☐ Stander
☐ Orthotics
☐ Walker
☐ Crutches
☐ Glasses
☐ Weighted vest or blanket
☐ Other_____
☐ Other_____
☐ Other_____

Vendor 1		Vendor 2		Vendor 3	
Name:		Name:		Name:	
Phone		Phone:		Phone:	
Fax:		Fax:		Fax:	

Current/Future Equipment Needs:	

Last review and updates:
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*Goals and Negotiated Actions - XX/XX/XXXX

IMMUNIZATIONS

as reported on XX/XX/XXXX from Children and Hoosiers Immunization Registry Program (CHIRP)

(insert CHIRP record here)

HOSPITALIZATIONS

(date, test/procedure name, location, result)

****information gathered on XX/XX/XXX and may not be complete***

SURGERIES

(date, test/procedure name, location, result)

****information gathered on XX/XX/XXX and may not be complete***

PROCEDURES

(date, test/procedure name, location, result)

****information gathered on XX/XX/XXX and may not be complete***

DIAGNOSIS SPECIFIC MONITORING

(date, location, outcome, next steps)

****information gathered on XX/XX/XXX and may not be complete***

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*Goals and Negotiated Actions - XX/XX/XXXX

FAMILY MEDICAL HISTORY

Condition	Who	Condition	Who
Coronary Artery Disease:		Hypertension:	
Mental Health:		Cancer Type:	
Neurodevelopmental:		Lipids:	
Diabetes:		Other:	
Genetic:		Other:	
NOTES:			

VITALS

Taken by XX on XX/XX/XXXX					
Height:		Weight:		BMI:	
Blood Pressure:		Resting Heart Rate:		Z-Score:	
Taken by XX on XX/XX/XXXX					
Height:		Weight:		BMI:	
Blood Pressure:		Resting Heart Rate:		Z-Score:	
Taken by XX on XX/XX/XXXX					
Height:		Weight:		BMI:	
Blood Pressure:		Resting Heart Rate:		Z-Score:	

NOTES/ADDITIONAL INFO

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*Goals and Negotiated Actions - XX/XX/XXXX

Goals and Negotiated Actions

	Action Items/strategies (To reach short term goals)	Person responsible	Status
Active Goals			
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
			☐Completed ☐In progress ☐On Hold ☐Dropped
Future Goals			
Other Resources			

Family Signature:	Clinician Signature:	Care Coordinator Signature:
Date:	**Date:**	**Date:**

Care Coordinator Contact Information

Name: _____
Phone: _____
Email: _____