

# Utah Care Notebook

Distributed by the Utah Collaborative Medical Home Project and the  
Utah Family Voices Health Information & Education Center at the  
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Bureau of Managed Health Care  
Utah Department of Health



For more information call the Utah Family Voices Health Information, Education &  
Support Center at: 801-584-8236, toll free 1-800-829-8200  
To download individual pages visit [www.medhomeportal.org](http://www.medhomeportal.org) under the For Families  
section

# Utah Care Notebook: A Quick Guide

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## What is a Care Notebook?

A Care Notebook is an organizing tool for families who have children with special health care needs. Use a Care Notebook to keep track of important information about your child's health care. This Care Notebook has been designed for families living in Utah.



## How can a Care Notebook help me?

In caring for your child with special health needs, you may get information and paperwork from many sources. A Care Notebook helps you organize the most important information in a central place. A Care Notebook makes it easier for you to find and share key information with others who are part of your child's care team.



## Use your Care Notebook to:

- Track changes in your child's medicines or treatments
- List telephone numbers for health care providers and community organizations
- Prepare for appointments
- File information about your child's health history
- Share new information with your child's primary doctor, public health or school nurse, daycare staff, and others caring for your child

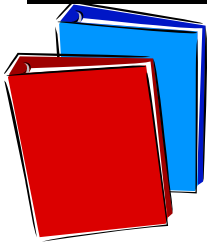


## What are some helpful hints for using my child's Care Notebook?

- Store the Care Notebook where it is easy to find. This helps you and anyone who needs information when you are not there.
- Add new information to the Care Notebook whenever your child's treatment changes.
- Consider taking the Care Notebook with you to appointments and hospital visits so that information you need will be easy to find.

# Setting up Your Care Notebook

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**Follow these steps to set up your child's notebook:**

## **Step 1: Gather information you already have.**

- Gather up any health information about your child you already have. This may include reports from recent doctor's visits, recent summary of a hospital stay, this year's school plan, test results, or informational pamphlets.

## **Step 2: Look through the pages of the Utah Care Notebook.**

- Which of these pages could help you keep track of information about your child's health or care?
- Choose the pages you like. Print copies of any that you think you will use. The Care Notebook pages are available from the Internet at [www.medhomeportal.org](http://www.medhomeportal.org). Go to **For Families** then choose **Managing and Coordinating Care** then **Utah Care Notebook**, you can select to download the whole notebook or just the forms you want and need.

## **Step 3: Decide which information about your child is most important to keep in the Utah Care Notebook.**

- What information do you look up often?
- What information do people caring for your child need?
- Consider storing other information in a file drawer or box where you can find it if needed.

## **Step 4: Put the Utah Care Notebook together.**

- Everyone has a different way of organizing information. The only important thing is to make it easy for **you** to find again. Here are some suggestions for supplies used to create a Care Notebook:
- 3-ring notebook** or large accordion envelope. Hold papers securely.
- Tabbed dividers.** Create your own information sections.
- Pocket dividers.** Store reports.
- Plastic pages.** Store business cards and photographs.



# Utah Care Notebook

## List of Pages

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### **Pages to Keep Track of Appointments and Care**

- ☀ Appointment Log
- ☀ Diet Tracking Form
- ☀ Equipment
- ☀ Supplies
- ☀ Growth Tracking Form
  - ☀ Growth Charts
- ☀ Hospital Stay Tracking Form
- ☀ Information Needed by Emergency Care Providers
- ☀ Lab Work/Tests/Procedures
- ☀ Medical Bill Tracking Form
- ☀ Medical Surgical Highlights
- ☀ **Medications**
- ☀ Notes

### **Pages to Create a Care Summary: Abilities and Special Care Needs**

- ☀ Activities of Daily Living
- ☀ Care Schedule
- ☀ Child's Page
- ☀ Communication
- ☀ Coping/Stress Tolerance
- ☀ Mobility
- ☀ Nutrition
- ☀ Respiratory
- ☀ Rest/Sleep
- ☀ Social/Play
- ☀ Transitions

### **Pages to Create A Care Team and Resource List**

#### Community Health Care/Service Providers:

- ☀ Medical / Dental
- ☀ Public Health
- ☀ Home Care
- ☀ Therapists
- ☀ Early Intervention Services
- ☀ School
- ☀ Child Care
- ☀ Respite Care
- ☀ Pharmacy
- ☀ Special Transportation
- ☀ Recreation Opportunities
- ☀ Family Information
- ☀ Family Support Resources
- ☀ Funding Sources

**Note:** You may use all or just a part of these pages. Not all of the pages may apply to your family situation. For example, your child may be over age 3, and therefore not involved in Early Intervention.

**Organize** your pages any way that works for you. (See "**Setting up Your Care Notebook.**")

**Use** dividers or tabs to help you organize your notebook. Sheet protectors, plastic pages and folders will also be helpful in organizing material.



# Diet Tracking Form

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

# Equipment

---

☼ **Medical Equipment Supplier (DME Supplier):** \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

Notes (delivery schedule, order schedule, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☼ **Name of Equipment:** \_\_\_\_\_

Description (brand name, size, etc.): \_\_\_\_\_

\_\_\_\_\_

Date Obtained: \_\_\_\_\_ Service Schedule: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

☼ **Name of Equipment:** \_\_\_\_\_

Description (brand name, size, etc.): \_\_\_\_\_

\_\_\_\_\_

Date Obtained: \_\_\_\_\_ Service Schedule: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

☼ **Name of Equipment:** \_\_\_\_\_

Description (brand name, size, etc.): \_\_\_\_\_

\_\_\_\_\_

Date Obtained: \_\_\_\_\_ Service Schedule: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_







## Emergency Preparedness for Children with Special Health Care Needs *Instructions for Parents*

Dear Parent:

Children with special health care needs have very unique medical histories and require very special medical treatment. If an emergency physician does not have access to this important information, these children are in danger of delayed treatment, unnecessary tests, and even serious errors. It is extremely important, then, that parents and physicians work together to give emergency physicians access to the special information they need to properly care for children with very special health care needs.

To address this problem, the American Academy of Pediatrics and the American College of Emergency Physicians have developed the Emergency Information Form. This simple form is used to record health information for children with special health care needs and should be kept in multiple locations for easy access by physicians and emergency medical personnel.

To complete this important form, follow these easy instructions:

1. **GET THE FORM:** Get the Emergency Information Form from the child's primary care physician, specialist, or the local emergency room.
2. **FILL IT OUT:** Begin filling out the form to the best of your ability. Take the form to the child's primary care physician or specialist and ask them to finish filling out the form.
3. **KEEP IT:** Keep 1 copy of the form in each of the following places:
  - a. **DOCTORS:** On file with each of the child's physicians, including specialists.
  - b. **ER:** On file with the local emergency rooms where the child is most likely to be treated in the case of an emergency.
  - c. **HOME:** At the child's home in a place where it can be easily found, such as the refrigerator.
  - d. **VEHICLES:** In each parent's vehicle (ie, glove compartment).
  - e. **WORK:** At each parent's workplace.
  - f. **PURSE/WALLET:** In each parent's purse or wallet.
  - g. **SCHOOL:** On file with the child's school, such as in the school nurse's office.
  - h. **CHILD'S BELONGINGS:** With the child's belongings when traveling.
  - i. **EMERGENCY CONTACT PERSON:** At the home of the emergency contact person listed on the form.
4. **REGISTER:** Consider registering the child, if he or she is not already registered, with MedicAlert®. Send MedicAlert® a copy of the form so that they can keep it stored in their central database, which is easily accessible by emergency medical personnel.
5. **UPDATE:** It is extremely important that you update the form every 2-3 years, and after any of the following events:
  - a. Important changes in the child's condition.
  - b. The performance of any major procedure.
  - c. Important changes in the treatment plan.
  - d. Changes in physicians.

Now, if your child ever has an emergency, the emergency medical personnel will have easy access to your child's very unique medical history, allowing them to provide your child with the best medical care available.

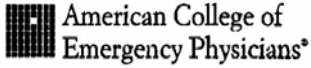
Thank you for your cooperation!

Very truly yours,  
*American Academy of Pediatrics*  
*American College of Emergency Physicians*  
*Emergency Medical Services for Children*

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American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000

# Emergency Information Form for Children With Special Needs



American Academy  
of Pediatrics



Date form  
completed  
By Whom

Revised  
Revised

Initials  
Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	Baseline neurological status:

\*Consent for release of this form to health care providers

<b>Diagnoses/Past Procedures/Physical Exam continued:</b>	
<b>Medications:</b>	<b>Significant baseline ancillary findings (lab, x-ray, ECG):</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	<b>Prostheses/Appliances/Advanced Technology Devices:</b>
5. _____	_____
6. _____	_____

<b>Management Data:</b>	
<i>Allergies: Medications/Foods to be avoided</i>	<b>and why:</b>
1. _____	_____
2. _____	_____
3. _____	_____
<i>Procedures to be avoided</i>	<b>and why:</b>
1. _____	_____
2. _____	_____
3. _____	_____

<b>Immunizations (mm/yy)</b>									
<b>Dates</b>						<b>Dates</b>			
DPT						Hep B			
OPV						Varicella			
MMR						TB status			
HIB						Other			

Antibiotic prophylaxis: \_\_\_\_\_ Indication: \_\_\_\_\_ Medication and dose: \_\_\_\_\_

<b>Common Presenting Problems/Findings With Specific Suggested Managements</b>		
Problem	Suggested Diagnostic Studies	Treatment Considerations

<b>Comments on child, family, or other specific medical issues:</b>

<b>Physician/Provider Signature:</b>	<b>Print Name:</b>
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Last name:











# Care Schedule

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TIME	CARE
<b>Morning</b>	

# Care Schedule

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TIME	CARE
Evening	
Night	

# Child's Page

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My name is: \_\_\_\_\_

My nickname is: \_\_\_\_\_

My pet is a: \_\_\_\_\_ My pet's name is: \_\_\_\_\_

My "favorites"

Toys: \_\_\_\_\_

Animal: \_\_\_\_\_

Games: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Songs: \_\_\_\_\_

T.V. Shows: \_\_\_\_\_

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

My favorite foods are: \_\_\_\_\_

My least favorite foods are: \_\_\_\_\_

My friends' names are: \_\_\_\_\_

When I am happy I: \_\_\_\_\_

When I am sad I: \_\_\_\_\_

When I feel pain I: \_\_\_\_\_

Things I need help with (like washing, dressing or brushing teeth): \_\_\_\_\_

Things I can do for myself (but thanks for asking!): \_\_\_\_\_

If you need to know something else, ask me or ask: \_\_\_\_\_

who can be reached by calling: (     ) \_\_\_\_\_



















# Medical / Dental

## Community Health Care Providers

---

☼ Primary / Community Care Provider: \_\_\_\_\_

Date of First Visit: \_\_\_\_\_

Office Nurse/Medical Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Primary Children's Medical Center

Medical Record Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Community or Specialty Hospital: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_

Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_

Office Nurse/Medical Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_

Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_

Office Nurse/Medical Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Dental Provider: \_\_\_\_\_

Date of First Visit: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Orthodontist: \_\_\_\_\_

Date of First Visit: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**There is space to list more Specialty Care Providers on the next page.**

# Providers (Continued)

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**Many specialty physicians may treat your child. You may keep track of some them here:**

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Community Specialty Care Provider: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Office Nurse/Medical Assistant: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

# Home Care Providers

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☼ Home Care Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Other Contacts (scheduler, billing, etc.): \_\_\_\_\_

Primary Care Nurse: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Home Care Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Other Contacts (scheduler, billing, etc.): \_\_\_\_\_

Primary Care Nurse: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Home Care Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Other Contacts (scheduler, billing, etc.): \_\_\_\_\_

Primary Care Nurse: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

# Therapists

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☼ **Occupational Therapist (OT):** \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency / Hospital / Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ **Physical Therapist (PT):** \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency / Hospital / Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ **Speech-Language Pathologist:** \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency / Hospital / Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

# Early Intervention

☼ The **Baby Watch Early Intervention Program** is a collection of services provided by public and private agencies and designed by law to support eligible children and families in enhancing a child's potential growth and development from **birth to age three**.

☼ My Baby Watch Early Intervention Program agency: \_\_\_\_\_  
 Date contacted: \_\_\_\_\_ Date started in program: \_\_\_\_\_  
 Service Coordinator: \_\_\_\_\_  
 Service Providers (therapist, nurse, etc.): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Schedule: \_\_\_\_\_  
 \_\_\_\_\_

If you live in this area:	Contact this Agency:	At this Telephone Number:
Juab, Millard, Sanpete, Sevier, Piute & Wayne Counties	Central Utah Health Department	435-896-5451
Davis County	Family Enrichment Center	801-402-7309
Salt Lake/Granite School District, Tooele or Duchesne Counties	DDI VANTAGE	801-266-3939
Cache, Rich, Box Elder Counties	Up-to-3 Child & Family Development Program	435-797-2043
Jordan School District	Child Development Center	801-412-2510
Alpine School District	Kids on the Move	801-221-9930
Nebo School District	Kids Who Count	801-423-3000
Provo School District	Provo Early Education Program	801-374-4965
Carbon, Emery and Grand Counties	Southeastern Utah District Health Department	435-637-3671
San Juan County	San Juan School District E.I.	435-678-1222
Summit and Wasatch Counties	Summit County Health Department E.I.	435-649-9072
Beaver, Iron, Garfield and Kane Counties	Southern Utah University E.I.	435-586-6070
Washington County	The Learning Center for Families	435-673-5353
Uintah and Daggett Counties	Prime Time 4 Kids	435-789-5409
Weber and Morgan Counties	Weber School District E.I.	801-626-2552
Statewide services	Deaf/Blind Services	801-629-4769
Statewide services	Parent Infant Program	801-629-4743

# School Contacts

(Some parents store IEP and 504 plan information in sheet protectors following this section.)

---

☼ **School District:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Web Site: \_\_\_\_\_

**Special Education Coordinator:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**504 Accommodation Plan Coordinator** (if different from above): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**District Nurse assigned to your child's school:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

---

☼ **School / Preschool:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Web Site: \_\_\_\_\_

**Principal / Administrator:** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Classroom Teacher:** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Resource Instructor:** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Aide / Assistant / Intervener:** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Special Education Director / Teacher(s):** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Therapist(s):** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Other Contacts:** \_\_\_\_\_

\_\_\_\_\_

# Child Care

---

☼ Child Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Important Information: \_\_\_\_\_

\_\_\_\_\_

☼ Child Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Important Information: \_\_\_\_\_

\_\_\_\_\_

☼ Child Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Important Information: \_\_\_\_\_

\_\_\_\_\_

# Respite Care

---

☼ Respite Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Respite Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Respite Care Provider: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**If applicable:**

Fiscal Agent: \_\_\_\_\_ Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

# Pharmacy

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Medical professionals suggest that, if possible, you use one pharmacy for all your prescription medicine needs. That way your pharmacist may keep track of all medications being used and any possible problems with interactions between medications. Sometimes, however, you may need to have prescriptions filled at your neighborhood pharmacy and other times you may need to have them filled at the hospital pharmacy. Use this space to keep track of all your pharmacy providers.

☼ Pharmacy: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Pharmacy: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Pharmacy: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Important information for the pharmacist (Such as allergies to medication):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Special Transportation

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☼ **Transportation (to and from medical / therapy appointments):**

Contact person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Important information** (such as bus route, rules regarding pick-up, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☼ **Transportation (to and from medical / therapy appointments):**

Contact person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Important information** (such as bus route, rules regarding pick-up, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Recreation

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A number of organizations have programs designed to give children and adults with special needs Recreation opportunities. These include local park and recreation programs. Check with your providers to find out more about recreation opportunities close to your home. Some parents include brochures and activity calendars in this section of their Utah Care Notebook.

☼ Recreation Opportunity: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Schedule: \_\_\_\_\_

☼ Recreation Opportunity: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Schedule: \_\_\_\_\_

☼ Recreation Opportunity: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Schedule: \_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Family Information

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☼ Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Blood Type: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

## *Family Members*

☼ Mother's Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

☼ Father's Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

☼ Sibling's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
☼ Sibling's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

☼ Other household members: \_\_\_\_\_

☼ Important Family Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☼ Language spoken at home: \_\_\_\_\_  
Other language(s): \_\_\_\_\_  
Interpreter Needed? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Preferred interpreter? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## *Emergency Contact*

☼ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

# Family Support Resources

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☼ Support Group / Organization: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Support Group / Organization: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Religious Organization: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Counseling Services: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Division of Services for People with Disabilities (DSPD): \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Other: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

☼ Other: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address/Directions: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

# Insurance, Etc.

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☼ Primary Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Secondary Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Medicaid (HMO Name if applicable – this is the company name that appears above your child’s name and ID Number on the Medicaid Identification Card): \_\_\_\_\_  
ID Number: \_\_\_\_\_  
Eligibility Worker: \_\_\_\_\_  
Office/Location of Eligibility Worker: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Supplemental Security Income (SSI): \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

☼ Other: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

