

Hitchcock Clinic—Concord Pediatric Care Plan Part I

Child's Name _____		Nickname _____		DOB _____	
Parent (Caregiver) _____			(Relationship) _____		
Address _____					
Phone #(home) _____		(Blocked? Y__N__)		Best time to reach _____	
E-mail _____					
Mom Alternate Phone _____			Dad Alternate Phone _____		
Emergency Contact _____		Phone _____		Relationship _____	
Emergency Contact _____		Phone _____		Relationship _____	
Health Insurance/Plan _____			Identification # _____		

Diagnose(s): <input type="checkbox"/> Emergency Plan		r Yes	r No	Complexity Level _____	
Primary _____	ICD9 _____	Primary _____	ICD9 _____		
Secondary _____	ICD9 _____	Secondary _____	ICD9 _____		
Secondary _____	ICD9 _____	Secondary _____	ICD9 _____		

Allergies/reaction: _____	

Medications/dose: _____	

PCP _____	Phone _____	Fax _____	E-Mail _____
#1 Specialist/Specialty _____	Clinic/Hospital _____	Phone _____	Other (fax, e-mail, etc.): _____
#2 _____			Other (fax, e-mail, etc.): _____
#3 _____			Other (fax, e-mail, etc.): _____
#4 _____			Other (fax, e-mail, etc.): _____

Nursing Service/Respite _____ **Phone** _____

Care Plan Part II: Child Description

Name _____ Nickname _____ DOB _____

Child's Assets & Strengths _____

Vital Sign (baselines)

Ht _____ Wt _____ Temp _____ Other _____

Challenges (check all that apply, please explain on lines below)

- | | | |
|--|---|--|
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Learning | <input type="checkbox"/> Stamina/Fatigue |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Orthopedic/Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Feed & Swallowing | <input type="checkbox"/> Physical Anomalies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing/Vision | <input type="checkbox"/> Sensory | <input type="checkbox"/> Other _____ |

Procedures/foods/activities to be avoided:

Prior surgeries/procedures:

_____	Date	_____	Date
_____	Date	_____	Date
_____	Date	_____	Date

Most recent labs/diagnostic studies:

Labs _____ EEG _____

_____ EKG _____

_____ X-rays _____

Drug levels _____ C-Spine _____

_____ Other _____

_____ Other _____

MRI/CT _____

Care Plan Part II: Child Description

Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

- | | | |
|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Adaptive Seating | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Communication Device | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Suction | <input type="checkbox"/> Monitors: () __Apnea __O2 | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Nebulizer | __Cardiac__Glucose | <input type="checkbox"/> Walker |
| | | <input type="checkbox"/> Other_____ |

School System/Child Care:

Contact Person/Role:

Phone:

Family Information:

Caregivers _____

Siblings _____

Other important facts _____

Special Circumstances/Comment/What you would like us to know

Parent /Caregiver Signature & Date

Primary Care Provider Signature & Date