

Universal Care Plan for the
MANAGEMENT AND CARE COORDINATION
OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Primary Care Provider _____ Phone # _____

Patient Name _____ Sex: M F

Emergency Plan Yes No In process

DOB: Mo. _____ day _____ year _____ -if 16 or older consider a Health Transition Plan YES No

Primary Language _____

Request for Interpreter YES No

Primary Insurance _____ ID _____

Caregiver/Guardian/Parent

Secondary Insurance _____ ID _____

Name _____

Medicaid ID _____ Provider _____

Phone _____

Is this a Medicaid Waiver? YES No

Address _____

(if yes, CIRCLE) HCBS Children's CES Other _____

City, State _____

CHP+? YES No

Zip code _____

HMO if known _____

MEDICAL HISTORY: continue on additional pages if needed:

IMMUNIZATIONS: Are immunizations up to date? Yes No

Is an immunization record available? (Yellow card) Yes No

MENTAL HEALTH: Is there a diagnosis? Yes No if yes, provider name _____

ALLERGIES:

CURRENT PROBLEM	Dx Code	Dx Code
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION Pharmacy Name _____ Phone & Fax _____

Medication/Doses	Reason for medication	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIALISTS/CLINICS/NAMES	Phone #	Last Visit	Need to return?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist- _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other- _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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FOOD/HYDRATION

Growth: Ht. _____ Wt. _____ Wt./Ht. _____ BMI _____

Growth Assessment: _____

Difficult Feeding Issues: Yes No explain _____

Allergies: _____

Feeding Evaluation: Yes No _____ Swallow Study: YES No Date _____

Nutrition Assessment: Yes No Date _____

Age appropriate textures and feeding: Yes No

Caloric/Nutrient/Fluid Intake Needs: _____

Registered Dietitian Services Yes No (Part C, HCP, Hospital) Name _____ Phone _____

Enteral Feeding: Yes No Type of Formula: _____ RX Needed? Yes No

Name of Nutrition Supplemental Products: _____

Nutrition Issues included on IFSP/IEP? Yes No

Dietician Services Yes No _____ Phone _____

Concerns _____

HOSPITAL / SURGERY / ER	Date	Procedures/MRI,CT, X-ray, Swallow study	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME HEALTH CARE / REHABILITATION

Nursing Agency _____ Phone _____ Concerns? _____

Home Health _____ Phone _____ Concerns? _____

DME Equipment/supplies _____

DME Equipment & date ordered _____

THERAPIES- PROVIDER / CLINIC Is a Prior Authorization Request Needed? Yes No

PT _____ Frequency _____ Phone _____

OT _____ Frequency _____ Phone _____

Speech _____ Frequency _____ Phone _____

Other _____ Frequency _____ Phone _____

Other _____ Frequency _____ Phone _____

COMMUNITY RESOURCES

IFSP? Yes No Date _____ IEP? Yes No Date _____

County of Residence _____

Is there a Health Care Action Plan? Yes No Date _____

Transition Plan? Yes No Date _____

CCB _____ Y N Contact _____ Date Referred _____

Early Intervention _____ Y N Contact _____ Date Referred _____

Child Find _____ Y N Contact _____ Date Referred _____

HCP _____ Y N Contact _____ Date Referred _____

SSI _____ Y N County Technician _____ Date Referred _____

School _____ Y N District _____ Grade _____

Related Services(special ed.) _____ Y N OT/PT/SP Services: _____

Behavioral/Mental Health _____ Y N Contact _____ Phone _____

WIC _____ Y N Contact _____ Phone _____

Referral to EPSDT Outreach? Yes No Contact _____

Last Updated _____

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<p>Visit DATE _____</p> <p>Professionals seen during-</p> <p>Recommendations-</p> <p>Follow-up- tests, lab work or medications-</p>

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