Individual Health Plan

Child's Name: _____ Sex: M F Date of Birth:____/____/_____

Parents: (Mom)_____(Dad)_____

Address: _____

Phone: Home# (____)_____ Cell# (_____) _____ Work# (_____)_____

PCP name: _____ Phone: (_____)_____ Fax #(_____)_____

SS#: _____-_____-_____ MMI :_____ MRN:_____

Insurance:_____

Referred By: _____Phone: (_____)_____Date: ____ /____/_____

Principle Diagnosis:_____

Problem List:

1._____ 7._____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12._____

Unique Clinical Facts: _____

_____

Medications:

Chronic (dose/date started/ended)

1._____ 7. _____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12_____

PRN- medications

1._____ 4._____

2._____ 5_____

3._____ 6._____

Allergies: _____

Immunizations: up to date _____ needs_____

Individual Health Plan: Name: _____ MMI:_____ MRN: _____

Date of Past Hospital Admits/Reason:

1._____ 5._____

2._____ 6. _____

3._____ 7._____

4. _____ 8._____

Consultants/Specialty /phone#/last visit date:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Home Care Nursing: Agency Name:_____

Contact: _____ phone: (_____)_____

Services Ordered: _____

Home Care Equipment: Company Name:_____ phone: (_____)_____

__ O2 stationary/portable
__Apnea monitor
__Trach tube type/size _____ / Cuff Yes/No
__Formula_____
__ N/G tube
__Carseat
__ BP monitor
__ O2 oximeter (SAT)
__ Suction machine/supplies
__Vent/type_____,
__Feeding pump/supplies
__GT/GJ (type_____ size___)
__Wheelchair
__ Other_____

Developmental /Rehab: Company Name:_____ phone: (_____)_____

__PT:_____ __ OT:_____

__Speech :_____ __ Vision:_____

School: _____ phone: (_____)_____

Community Resources:

__ DSPD: Caseworker_____ phone: (_____)_____
__ SSI
__ Waiver Program: __Technology Dependent Children __TBI __DDMR
__ WorkForce Service: __Food Stamps __Child Care
__ WIC
__ Housing Assistance
__ Medicaid: Caseworker_____ phone: (_____)_____

Mental Health: _____ phone: (_____)_____

Other:_____

Team Goals/ Family Meetings: **Last revision date: _____**

1._____ 4._____

2._____ 5._____

3._____ 6._____