Utah Pediatric Shared Plan of Care Template

To be used with the

Care Coordination Information Checklist

Completed by: Click here to enter text. **Last updated:** Click here to enter text.

Patient Information:

Complexity Level: Choose one **Insurance:** Insurance Policy **Chart Number:** Number

Patient Name: Click here to enter text.
Date of Birth: Click here to enter text.
Parent: Click here to enter text.
Relationship: Click here to enter text.
Phone: Click here to enter text.

Educational Information:

School Name: Click here to enter text.
Grade: Click here to enter text.
Person of contact: Click here to enter text.
Phone: Click here to enter text.
School Information: Click here to enter text.

Current Plans:
☐ IFSP
☐ IEP
☐ 504
☐ IHP

Challenges:

☐ Behavioral
☐ Learning
☐ Physical Anomalies
☐ Respiratory
☐ Communication
☐ Sensory
☐ Orthopedic/Musculoskeletal
☐ Feeding/Swallowing
☐ Hearing/Vision
☐ Stamina/Fatigue
☐ Social
☐ Sleeping
☐ Nutrition
☐ Education
☐ Other: Click here to enter text.

Equipment Needs/Assistive Technologies:

☐ Gastronomy
☐ Adaptive Seating
☐ Wheelchair
☐ Orthotics
☐ Stander/Walker
☐ Crutches/Braces
☐ Feeding Pump
☐ Tracheostomy
☐ Suction
☐ Nebulizer
☐ Communication Device
☐ Hearing Aids/Cochlear
☐ Monitors:
☐Apnea ☐O2 ☐Glucose ☐Cardiac

☐ Other: Click here to enter text.

Special Clinical Accommodations:

☐ Room immediately
☐ Dim lighting
☐ Low volume
☐ Sensory toys
☐ Minimize wait
☐ Picture communication
☐ Wheelchair access
☐ Other: Click here to enter text.

Current Services:

☐ Early Intervention
☐ Transition
☐ SPED
☐ SLP
☐ PT
☐ OT
☐ APE
☐ PSY
☐ Home Health

		☐ Other: Click here to enter text.

Chronic Condition Management:

Problem List:

Diagnosis	ICD-10 Code
primary diagnosis.	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code
Secondary diagnosis	ICD 10 code

Treatment:

Clinical Goals / Action Items	Date of Last Visit	Need notes?	Specialist/Care Provider Responsible	Follow-Up Date
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Behavioral Goals / Action Items	**Date of Last Visit**	**Need notes?**	**Specialist/Care Provider Responsible**	**Follow-Up Date**
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Social or Community Goals / Action Items	**Date of Last Visit**	**Need notes?**	**Specialist/Care Provider Responsible**	**Follow-Up Date**
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.

Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Educational Goals / Action Items	**Date of Last Visit**	**Need notes?**	**Specialist/Care Provider Responsible**	**Follow-Up Date**
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.
Financial Goals / Action Items	**Date of Last Visit**	**Need notes?**	**Specialist/Care Provider Responsible**	**Follow-Up Date**
Click here to enter text.	Click here to enter text.		Click here to enter text.	Click here to enter text.

Medications: Click here to enter text.

Name	Dosage	Frequency
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Allergies: Click here to enter text.

Click here to enter text.

Recent Labs: Click here to enter text.

Type	Result	Date
Click here to enter text.	Click here to enter text.	Click here to enter a date.
Click here to enter text.	Click here to enter text.	Click here to enter a date.
Click here to enter text.	Click here to enter text.	Click here to enter a date.
Click here to enter text.	Click here to enter text.	Click here to enter a date.

Care Team Information:

Provider	Location	Phone	Fax
PCP: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Specialist: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Agency: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Agency: Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Home Nursing/Respite Care? ☐ Yes ☐ No			
If yes, organization & phone: Click here to enter text.			

Do you consent to share with the Care Team members / agencies above?

X ______________________

Family/Guardian Signature

X ______________________

Physician/Provider Signature

Patient:
DOB:
MRN:

Previsit Planning:
Date of last Health Supervision Visit:
Date of last Care Conference:

Attendees:

Agenda
Family Updates:

Wellness:

Strengths:

Challenges:

Medical Updates:

-Diagnosis/Medical History:
-Specialist :
-Medications:

School Updates:

-Case Manager:
-SLP/OT/PT:
-School RN:

Community Partner Updates:

Goals numbered in level of priority:

Goals

None

1. {smartgoals:41769}
2. {smartgoals:41769}
3. {smartgoals:41769}

Action Items:

Next Care Conference:
Upcoming Appointments: Visit date not found

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Child's Name:	**Child likes to be called:**	**DOB:**	**Updated Date:**
Phone: (days) (eves/weekends)		**Email address:**	
Insurance Company:		**I have access to the internet:** ☐ **YES** ☐ **NO**	
Emergency contact and phone:			

I want the person working with me to know…

Child has challenges with: ☐ Transportation ☐ Vision ☐ Hearing ☐ Mobility ☐ English as a second language (ESL) ☐ Other

Comments:

I am concerned about:

☐ Managing my chronic condition ☐ Working with the school ☐ Financial Issues

☐ Having access to healthcare ☐ Emotional issues ☐ Family issues

☐ Spiritual support ☐ Other: _____

Child has issues with diet: ☐ YES ☐ NO Comments:

Our religion/spirituality impacts his/her health care: ☐ YES ☐ NO Comments:

CARE TEAM/MEDICAL HOME NEIGHBORHOOD	**Name**	**Best contact method (phone/e-mail)**	**Best contact time (am / pm)**
My Primary Care Provider:			
My Provider's nurse:			
My specialist(s):			
My mental health care provider:			
My school nurse or primary teacher:			
DME			
Home Health Agency			
Case Manager			

I authorize that my child's personal health record to be shared with his/her care team listed above: ☐ YES ☐ NO

Others with whom I agree to view my child's plan include:

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My child lives with:			
Name:	☐ Mother ☐ Father ☐ Step-parent	☐ Brother ☐ Sister ☐ Grandparent ☐ Foster parent ☐ Guardian	☐ Full time ☐ Alternate weeks ☐ Weekends ☐ Summers
Name:	☐ Mother ☐ Father ☐ Step-parent	☐ Brother ☐ Sister ☐ Grandparent ☐ Foster parent ☐ Guardian	☐ Full time ☐ Alternate weeks ☐ Weekends ☐ Summers
Name:	☐ Mother ☐ Father ☐ Step-parent	☐ Brother ☐ Sister ☐ Grandparent ☐ Foster parent ☐ Guardian	☐ Full time ☐ Alternate weeks ☐ Weekends ☐ Summers
Name:	☐ Mother ☐ Father ☐ Step-parent	☐ Brother ☐ Sister ☐ Grandparent ☐ Foster parent ☐ Guardian	☐ Full time ☐ Alternate weeks ☐ Weekends ☐ Summers

My child learns best by: ☐ Reading ☐ Being talked to ☐ Being shown how ☐ Listening to tapes ☐ Seeing pictures or video

Upcoming Appointments

Next Appointment	Name	Office Phone #	On-call #	Role

Medical Condition / Diagnosis

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Modified from the version developed by the Pursuing Project in Whatcom County

Special Health Care Needs

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Drug Allergies/Intolerance	Reaction	Date Occurred	Comments
Other Allergies:			

Over-the-counter Medication I take:

Name	Directions	Times Taken	Why I take this?	Pharmacy	Comments

Prescription Medications / Treatments / Therapies

Date	Prescribed by	Drug Name	Directions	Why I take this?	B 8am-9pm	L 12pm -1 pm	D 6pm-8pm	Bed 9pm-11pm	Comments
					☐	☐	☐	☐	
					☐	☐	☐	☐	
					☐	☐	☐	☐	
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					☐	☐	☐	☐	
					☐	☐	☐	☐	

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Medications & Dosage I have stopped taking / Treatments that did not work									
Date I stopped taking it	Prescribed by	Drug Name	Directions	Why I took this?	B 8am-9pm	L 12pm -1 pm	D 6pm-8pm	Bed 9pm-11pm	Why I stopped taking this?
					☐	☐	☐	☐	
					☐	☐	☐	☐	
					☐	☐	☐	☐	
					☐	☐	☐	☐	
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					☐	☐	☐	☐	
					☐	☐	☐	☐	
					☐	☐	☐	☐	

My Next Steps

This section to be completed by you in partnership with your care team. Steps may include concerns about medical condition, problems, barriers or goals and are followed by action, solutions, the current status of the step, etc.

Date	*Concerns / Barriers / Actions / Comments / Status*	*By Whom*

_____ _____ _____

Provider Signature ***Parent/Guardian signature*** ***Date***

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Shared Plan of Care Action Plan

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Child's Name: **DOB:** **Parent/Guardian Name:**

Today's Concerns:

For Next Visit

- ☐ Care Coordination Needs / Referrals
- ☐ New Meds
- ☐ Family Ed Need
- ☐ Family / Child / Medical Home Care Plan
- ☐ Referral letters/ Contact needs for family
- ☐ Labs Needed
- ☐ Other
- ☐ Follow Up Needed
  - ☐ Call (Who/date/subject) _____
  - ☐ Next Visit (Schedule period/date) _____
  - ☐ Next Visit agenda _____

Child will:

_____

_____ **By:** (date) _____

Parent/Guardian will:

_____

_____ **By:** (date) _____

Medical Home will:

_____

_____ **By:** (date) _____

_____ _____ _____

Provider Signature ***Parent/Guardian signature – plan reviewed*** ***Date***

Phone: _____ Phone: _____

E-mail address: _____ E-mail address: _____

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Special Health Care Needs