



Date completed: _____

La Rabida Children's Hospital Premier Kids

Name: _____ Nickname: _____ DOB: _____ Gender: M F

Caregiver1 Name: _____

Address: _____ City/Zip: _____

Caregiver1 Phone: _____
(home) (work) (cell)

Caregiver2 Name: _____

Address: _____ City/Zip: _____

Caregiver2 Phone: _____
(home) (work) (cell)

Emergency Contact Name(s) _____

Relationship: _____ Phone: _____

Insurance: _____ Primary Language: _____

Do you have any transportation needs?

(Please explain): _____

Diagnosis	ICD-9 Code

Challenges (Check ALL that apply and explain on the line below):

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Learning | <input type="checkbox"/> Stamina/Fatigue | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Feeding/Swallowing | <input type="checkbox"/> Hearing/Vision |
| <input type="checkbox"/> Physical Anomalies | <input type="checkbox"/> Sensory | <input type="checkbox"/> Other: _____ | |

Explain: _____

FLU SHOT PRIORITY (check if yes) RSV prophylaxis (check if yes)

Pharmacy (name/phone): _____

Special Formulas: _____ Route: PO G Tube _____ water flush

Nutritional Needs: _____ Current/Previous Weights: _____

Allergies: _____

Medications	Rx (dose, route, frequency)	Ordered by/date	D/C date

Primary M.D. Specialists	Phone/Fax numbers	Type of Specialty/Hospital affiliations	Last / Next Appt. Date <i>(frequency of follow-up)</i>

Hospitalizations (name of hospital)	Dates (to/from)	Condition Treated/Surgery

EI Case Coordinator:

EI Site:

Therapists (PT/OT/ST/DT)	Phone/Fax numbers	Frequency of Services

School Services: Special Education IEP Name of School: _____

School Nurse (name/phone): _____

School Teachers/Therapists: _____

Social worker, Counselor/Dean: _____

Other Service Agencies (Early Intervention, DSCC, Home Health Care, Care Coordinators, Respite, etc.): _____

Dentist: _____

Past Procedures/Physical Exam:	N/A		
1.		Baseline physical findings:	N/A
2 .			
3.		Baseline vital signs:	N/A
4.			
Lab/X-ray Test Results:	N/A		
		Baseline neurological status:	N/A

Common Presenting Problems/Findings with Specific Suggested Managements		
Problem:	Suggested Diagnostic Studies:	Treatment Considerations:

Comments on child, family, or other specific medical issues:

DME: Equipment & Supplies

- | | | | | |
|---|---|---------------------------------------|---|--|
| <input type="checkbox"/> Adaptive Seating | <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> BP monitor | <input type="checkbox"/> Car Seat | <input type="checkbox"/> Cardiac Monitor |
| <input type="checkbox"/> Communication Device | <input type="checkbox"/> Crutches | <input type="checkbox"/> Feeding pump | <input type="checkbox"/> Formula | <input type="checkbox"/> Glucose Monitor |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> O ₂ Stationary/Portable | |
| <input type="checkbox"/> Orthotics | <input type="checkbox"/> Suction Machine/supplies | | <input type="checkbox"/> Trach tube type/size _____ /Cuff-y/n | |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Vent/type_____ | | <input type="checkbox"/> G tube type/size_____ | |
- Other: _____

DME Supplier: _____

Community Resources (Check ALL that apply and explain on the line below):

- DSCC: Caseworker: _____ (name/phone/fax)
- Early Childhood: Caseworker: _____ (name/phone/fax)
- Housing Assistance: Caseworker: _____ (name/phone/fax)
- Medicaid: Caseworker: _____ (name/phone/fax)
- DCFS: Caseworker: _____ (name/phone/fax)
- SSI Waiver Program: Technology Dependent Children TBI DDMR
- WIC Work Force Service: Food Stamps Child Care

Permissions

I give my permission to share the information in this care plan with all of my child's providers and those listed in this plan.

EXCEPT:

I give permission for the staff of Premier Kids Program to share my information with other community contacts (Parent Groups, Community resources, etc.) to help provide better care for my child/ren.

Parent/Legal Guardian Signature: _____ Date: _____ / _____ / _____

Date plan sent to providers: _____ by: _____

Primary Care Physician Signature/Date: _____

Completed by: _____

Extra room if necessary:

Surgery type	Dates (to/from)	Hospital	Surgeon
Medications	Rx (dose, route, frequency)	Ordered by/date	D/C date