



Date completed: \_\_\_\_\_

# North Arlington Pediatrics Care Plan (short)

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F

Mother Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Father Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Mother Phone: \_\_\_\_\_

Father Phone: \_\_\_\_\_

(home)

(work)

(cell)

Email: \_\_\_\_\_ Caregiver(s): \_\_\_\_\_

Insurance: \_\_\_\_\_ Primary Language: \_\_\_\_\_

**Are there any special parking or arrival (waiting/exam room) needs that you would like us to know about?**

(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: \_\_\_\_\_

Immunizations up to date?  Yes  No

Other Vaccines: \_\_\_\_\_

**FLU SHOT PRIORITY**  (check if yes)

Pharmacy (name/phone): \_\_\_\_\_

Special Formulas: \_\_\_\_\_

Allergies: \_\_\_\_\_

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

Specialists	Phone/Fax numbers	Hospital affiliations	Last / Next Appt. Date

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

Surgery type	Dates (to/from)	Hospital	Surgeon

Therapists (PT/OT/ST/DT)	Phone/Fax numbers	Facility/Site (address)	Services/Plan

School Nurse (name/phone): \_\_\_\_\_

School Teachers/Therapists: \_\_\_\_\_

Social worker, Counselor/Dean: \_\_\_\_\_

**DME: Equipment & Supplies**

- Apnea Monitor     
  Cardiac Monitor     
  Nebulizer     
  O<sub>2</sub> Stationary/Portable  
 Other: \_\_\_\_\_

DME Supplier: \_\_\_\_\_ (name/phone/fax)

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

- Medicaid: 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 North Arlington Pediatrics staff 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: \_\_\_\_\_

Completed by: \_\_\_\_\_