

Family and Physician Management Plan Summary for Children and Adolescents with Cerebral Palsy

The Management Plan Summary should be completed at each annual review and more often as needed. It is intended to be used with the Guidelines for Care, which provide a more complete listing of clinical issues at different ages and recommended evaluations and treatments.

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Family's Questions					
Growth/Nutrition/Feeding Feeding problems Slow weight gain, linear growth Questions about specialized feeding, gastrostomy care					
Associated Medical Problems Recurrent respiratory problems or aspiration Gastroesophageal reflux (GER) Seizures Toilet training (assess need for adaptive seating) Constipation, urinary incontinence Drooling Muscle cramps Hearing loss Strabismus/visual problems Sleep disorder, sleep apnea Note any side effects of medications.					
Cause of the Disability					

Family and Physician Management Plan Summary for Children and Adolescents with Cerebral Palsy (continued)

Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Dental Care					
Ambulation and Mobility Describe current ambulatory status Questions about physical therapy, braces, adaptive equipment Need for power-drive wheelchair					
Seating and Positioning					
Upper-Extremity Function and Visual Motor Skills					
Musculoskeletal Problems Recent change in contractures, gait, scoliosis					
Associated Developmental or Learning Issues Current school achievement Review early intervention (EI) or school services (individualized family service plan [IFSP] or individualized education program [IEP]) Developmental delay or mental retardation Learning disabilities					

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Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Associated Behavior/Mental Health Problems					
Social Skills Involvement in peer group activities in school and community (determine which supports are needed)					
Self-Care/Independence					
Family Support Services					
Treatment of Hypertonicity					
Communication/Speech Questions about speech services Need for augmentative and alternative communication (AAC) device(s) or a computer for written communication					

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Child's name _____ Person completing form _____ Today's date _____

Clinical issues	Currently a problem?	Evaluations needed	Treatment recommendations	Referrals made	Date for status check
Anticipatory Guidance List issues discussed and materials provided					
Collaboration with Community Agencies School					
Comments					

Next update of the Management Plan Summary _____

Signature _____ Date _____
(Child and parent)

Signature _____ Date _____
(Health professional)