Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele

This form will help you and your physician review current services and service needs. Please answer the questions about your current services on this page. Your physician will review your responses and complete the rest of the form.

Child's name ______________________ Today's date __________

Person completing the form ______________________

CURRENT SERVICES

1. Please list your/your child's current medications and any side effects.

2. What braces and special equipment do you/does your child use now?

3. What is your/your child's current school program?

   School name ______________________ Grade __________

   Teacher ______________________ Telephone __________

4. Do you/does your child receive any support services or other special programs at school (e.g., physical therapy, resource room)? Please list.

5. Who are your/your child's other medical and dental service providers?

   Dentist ______________________

   Neurosurgeon ______________________

   Orthopedist ______________________

   Urologist ______________________

   Other ______________________

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Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele *(continued)*

6. Who are your/your child's other community service providers?

   Physical therapist ______________________________

   Community health nurse ______________________________

   Other ______________________________

7. Do you/does your child also receive services from a spina bifida team of specialists?

   Contact person ______________________________

   Location ______________________________

8. Have you/has your child had any blood tests, radiologic (X-ray) examinations, or other procedures since your last visit? If yes, please describe.

9. Have you/has your child been hospitalized or received surgery since your last visit? If yes, describe.

10. Please note accomplishments since your last visit. Consider activities at home, in your neighborhood, or at school, as well as success with treatments.

11. What goals (i.e., skills) would you/your child like to accomplish in the next year? Consider activities at home, in your neighborhood, or at school, as well as success with a treatment.

12. What questions or concerns would you like addressed today?

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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 as well as 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					
Cause of the Neural Tube Defect (NTD) Counsel about folic acid use					
Growth/Nutrition Feeding problems, obesity					
Dental Care					
Respiratory Problems Stridor, apnea Sleep disordered breathing					
Skin Care and Decubiti Performing regular skin checks					
Latex Allergy Discuss primary and secondary prevention					

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Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele (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
Neurosurgical Problems Rapid head growth Recent change in neurologic examination or upper-extremity weakness					
Urologic Problems Current continence program Recent change in continence Today's urinalysis results					
Bowel Problems Describe current continence program Constipation or impaction					
Musculoskeletal Problems Recent change in contractures, gait, or scoliosis					
Ambulation and Mobility Describe current ambulatory status Questions about physical therapy (PT) services, braces, or adaptive equipment					
Seating and Positioning					

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Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele (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
Upper-Extremity Function/ Visual Motor Skills Increase in upper-extremity weakness or spasticity Questions about services					
Associated Medical Problems Seizures Strabismus/visual concerns Autonomic dysreflexia Precocious puberty **Note any side effects of medications.**					
Associated Developmental and Learning Problems Review early intervention or school services (individualized family service plan [IFSP], individualized education program [IEP]) Describe current school achievement Nonverbal learning disabilities (NVLD) Developmental delay or mental retardation					

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Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele (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**
Associated Behavior and Mental Health Problems					
Social Skills Involvement in peer-group activities in school and in the community					
Self-Care and Independence					
Family Support Services					
Anticipatory Guidance List issues discussed and materials provided					

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Family and Physician Management Plan Summary for Children and Adolescents with Meningomyelocele (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
Collaboration with Community Agencies School Developmental Disability Services Vocational Rehabilitation					
Comments					

Next update of the Management Plan Summary ______________

Signature ______________ Date ______________
(Child and parent)

Signature ______________ Date ______________
(Health professional)

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