# Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury

*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 and 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 ______________________
   Neurologist ______________________
   Orthopedist ______________________
   Other ______________________

6. Who are your/your child's other community service providers?
   Physical therapist ______________________
   Community health nurse ______________________
   Other ______________________

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## Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury *(continued)*

7. Do you/does your child also receive services from a neurodevelopmental 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 undergone surgery since your last visit? If yes, describe.

10. Please note your/your child's accomplishments since the 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* | | | | | |
| *Growth/Nutrition Concerns*<br>Feeding problems, dysphagia<br>Slow weight gain, linear growth<br>Questions about specialized feeding, gastrostomy care | | | | | |
| *Dental Care* | | | | | |
| *Musculoskeletal Issues*<br>Change in range of motion, gait, scoliosis | | | | | |
| *Ambulation and Mobility*<br>Describe ambulatory status<br>Questions about physical therapy (PT), braces, adaptive equipment<br>Assess need for power-drive wheelchair | | | | | |

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## Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury (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 |
|---|---|---|---|---|---|
| *Seating and Positioning* | | | | | |
| *Upper-Extremity Function/ Visual-Motor Skills* | | | | | |
| *Treatment of Hypertonicity* | | | | | |
| *Other Medical Issues*<br>Recurrent respiratory problems or aspiration problems<br>Gastroesophageal reflux (GER)<br>Seizures<br>Dizziness (vertigo)<br>Toilet training (determine need for adaptive seating)<br>Constipation, enuresis, urinary incontinence<br>Drooling<br>Muscle cramps<br>Hearing loss<br>Strabismus/visual problems<br>Sleep disorder<br><br>**Note any side effects of medications.** | | | | | |

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# Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury (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 |
|---|---|---|---|---|---|
| *Communication and Speech Progress*<br>Questions about speech services<br>Need for augmentative and alternative communication (AAC) devices or a computer for written communication | | | | | |
| *Associated Developmental/ Learning Issues*<br>Describe current school progress<br>Review early intervention or other school services (individualized family service plan [IFSP] or individualized education program [IEP])<br>School reentry<br>Memory problems<br>Executive function problems<br>Difficulty with information processing<br>Central auditory processing impairment | | | | | |

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# Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury (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/ Mental Health Issues* | | | | | |
| *Social Skills*<br>Involvement in peer-group activities in school or in the community (determine which supports needed) | | | | | |
| *Self-Care and Independence* | | | | | |
| *Family Support Services* | | | | | |
| *Anticipatory Guidance*<br>List issues discussed and materials provided | | | | | |
| *Collaboration with Community Agencies*<br>School<br>Developmental Disability Services<br>Vocational Rehabilitation | | | | | |

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# Family and Physician Management Plan Summary for Children and Adolescents with Traumatic Brain Injury (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 |
| --- | --- | --- | --- | --- | --- |
| Comments | | | | | |

Next update of the Management Plan Summary ____________________

Signature ______________________________ Date ____________________
(Child and parent)

Signature ______________________________ Date ____________________
(Health professional)

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