



## Family and Physician Management Plan Summary for Children and Adolescents with Developmental Delay or Mental Retardation *(continued)*

6. Do you/does your child also receive services from a child development team of specialists?  
Contact person \_\_\_\_\_  
Location \_\_\_\_\_
7. Have you/has your child had any blood tests, radiologic (i.e., X-ray) examinations, or other procedures since your/your child's last visit? If yes, please describe.
8. Have you/has your child been hospitalized or undergone surgery since your/your child's last visit? If yes, describe.
9. Please note your/your child's accomplishments since your last visit. Consider activities at home, in your neighborhood, or at school, as well as success with treatments.
10. 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 treatments.
11. 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 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 problems Slow weight gain Gastroesophageal reflux Obesity Short stature					
Associated Medical Problems Hearing loss Strabismus/vision problems Seizures Hypotonia Musculoskeletal issues (e.g., scoliosis, foot deformity) Drooling Sleep disorder Constipation Toilet training Sexuality, menstrual hygiene <b>Note any side effects of medications.</b>					
Cause of the Disability					

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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
Dental Care					
Associated Behavior/ Mental Health Problems Autism Aggression Inattention/hyperactivity Oppositional behavior Anxiety, depression Obsessive-compulsive behaviors Stereotypies Self-injurious behaviors (SIBs)					
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]) Speech-language disorder (need for augmentative and alternative communication devices)					
Need for Physical Therapy or Occupational Therapy Services Hypotonia Associated dyspraxia or cerebral palsy Fine motor/visual motor concerns					

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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
Behavior Management in the Home					
Behavior Management in the School					
Discussion of Alternative (Controversial) Therapies					
Social Skills Determine which supports are needed to promote involvement in peer group activities at school and in the community					
Self-Care/Independence					
Anticipatory Guidance List issues discussed and materials provided					
Family Support Services					

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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
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)