PATIENT NAME _____DOB _____ DATE _____

MEDICAL SUMMARY

DIAGNOSIS / PROBLEM LIST / HISTORY

DENTAL HOME? _____ YES _____ NO

If no dentist, do you need assistance locating and scheduling one? _____ YES _____ NO

ALLERGIES _____ NKA

MEDICATIONS _____ NONE

MEDICATION NAME	DOSE	FREQUENCY

SPECIALISTS _____ NONE

NAME	ADDRESS	PHONE / FAX

PATIENT NAME _____DOB _____ DATE _____

HOSPITALIZATIONS _____ NONE

NAME OF FACILITY	REASON / SURGERY	DATE

MENTAL HEALTH PROVIDERS _____ NONE

NAME	ADDRESS	PHONE / FAX

SUPPORT SERVICES _____ NONE

SERVICE	FREQUENCY / TYPE	CONTACT INFORMATION
HOME CARE (NURSING)		
DME (DURABLE MEDICAL EQUIP)		
PHYSICAL THERAPY		
OCCUPATIONAL THERAPY		
SPEECH THERAPY		
SCHOOL DISTRICT		
EARLY INTERVENTION		
IU-13		
OTHER SERVICES		

I give my authorization / permission for Berks / Exeter Pediatrics to discuss / share my child's special healthcare needs for coordination of care with all of the providers and support services listed on this medical summary.

Parent / Guardian Signature: _____