# Medical Summary and Emergency Care Plan

## Six Core Elements of Health Care Transition 2.0

| This document should be shared with and carried by youth and families/caregivers. | |
|---|---|
| Date Completed: | Date Revised: |
| Form completed by: | |
| **Contact Information** | |
| Name: | Nickname: |
| DOB: | Preferred Language: |
| Parent (Caregiver): | Relationship: |
| Address: | |
| Cell #: Home #: | Best Time to Reach: |
| E-Mail: | Best Way to Reach: Text Phone Email |
| Health Insurance/Plan: | Group and ID #: |

| **Emergency Care Plan** | | |
|---|---|---|
| Emergency Contact: | Relationship: | Phone: |
| Preferred Emergency Care Location: | | |
| Common Emergent Presenting Problems | Suggested Tests | Treatment Considerations |
| | | |
| | | |
| Special Concerns for Disaster: | | |

| **Allergies and Procedures to be Avoided** | |
|---|---|
| Allergies | Reactions |
| | |
| | |
| | |
| To be avoided | Why? |
| ☐ Medical Procedures: | |
| ☐ Medications: | |

| **Diagnoses and Current Problems** | |
|---|---|
| Problem | Details and Recommendations |
| ☐ Primary Diagnosis | |
| ☐ Secondary Diagnosis | |
| ☐ Behavioral | |
| ☐ Communication | |
| ☐ Feed & Swallowing | |
| ☐ Hearing/Vision | |
| ☐ Learning | |
| ☐ Orthopedic/Musculoskeletal | |
| ☐ Physical Anomalies | |
| ☐ Respiratory | |
| ☐ Sensory | |
| ☐ Stamina/Fatigue | |
| ☐ Other | |

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| Medications | | | | | |
|---|---|---|---|---|---|
| Medications | Dose | Frequency | Medications | Dose | Frequency |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Health Care Providers | | | | |
|---|---|---|---|---|
| Provider | Primary and Specialty | Clinic or Hospital | Phone | Fax |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Prior Surgeries, Procedures, and Hospitalizations | |
|---|---|
| Date | |
| Date | |
| Date | |
| Date | |
| Date | |

| Baseline | | | | | |
|---|---|---|---|---|---|
| Baseline Vital Signs: | Ht | Wt | RR | HR | BP |
| Baseline Neurological Status: | | | | | |

| Most Recent Labs and Radiology | | |
|---|---|---|
| Test | Date | Result |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| EEG | | |
| EKG | | |
| X-Ray | | |
| C-Spine | | |
| MRI/CT | | |
| Other | | |
| Other | | |

| Equipment, Appliances, and Assistive Technology | | | |
|---|---|---|---|
| ☐ Gastrostomy | ☐ Adaptive Seating | | ☐ Wheelchair |
| ☐ Tracheostomy | ☐ Communication Device | | ☐ Orthotics |
| ☐ Suctions | Monitors: | | ☐ Crutches |
| ☐ Nebulizer | ☐ Apnea | ☐ O2 | ☐ Walker |
| | ☐ Cardiac | ☐ Glucose | |
| ☐ Other | | | |

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| School and Community Information | | |
|---|---|---|
| Agency/School | Contact Information | |
| | Contact Person: | Phone: |
| | Contact Person: | Phone: |
| | Contact Person: | Phone: |

Special information that the youth or family wants health care professionals to know

| | | | |
|---|---|---|---|
| Youth signature | Print Name | Phone Number | Date |
| Parent/Caregiver | Print Name | Phone Number | Date |
| Primary Care Provider Signature | Print Name | Phone Number | Date |
| Care Coordinator Signature | Print Name | Phone Number | Date |

Please attach the immunization record to this form.