Vermont Integrated Communities Care Management Learning Collaborative

sShared Plan of Care (Medical Summary & Negotiated Actions)

SEE EMERGENCY CARE INFORMATION ON PAGE 2

PATIENT INFORMATION

First Name:	Last Name:	Middle:	Sex:	Birthdate:	Age:	MRN/System:

ABOUT ME

[INSERT PICTURE]

Strengths & preferred activities:	
How I learn:	
Interaction tips:	
Communication style:	
Tips to avoid triggers/behaviors:	
Mobility:	

DEMOGRAPHIC INFORMATION

Primary contact last name:	First:	Relationship to patient:

Street Address:	City:	State:	Zip:

Mailing Address:	City:	State:	Zip:

Email (Preferred? ☐Y ☐N):	Phone (Preferred? ☐Y ☐N):	Secondary Phone (Preferred? ☐Y ☐N):

Legal Decision Maker Information:

Emergency Contact Information:

Insurance Information

Primary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	
Secondary insurance:		ID number:			
Policy holder:		Employer:		Policy holder birthdate:	

Waiver	Type:		☐ Waiting List	Date applied:	
Medicaid redetermination date:					

Who are the people living in your home(s)? (Include you, and any other children or adults living with you.)

Primary Household			Secondary Household		
First and last names	Age	Relationship to your child	First and last names	Age	Relationship to your child
Self		**Self**			

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ALERTS

EMERGENCY/ADVANCED CARE INFORMATION:

**If needed, please see attached emergency or advanced care plan.*

MEDICATION ALLERGIES:

VITAL SIGNS

Height:		Weight (date):	
Baseline BP/HR:		Baseline RR:	
BMI:		Percentile:	Z-score:

CONDITIONS & MEDICAL HISTORY LIST

DIAGNOSIS		DATE OF DIAGNOSIS	DIAGNOSIS		DATE OF DIAGNOSIS
Birth/Genetic:			Cardiovascular:		
Dental:			Endocrine:		
Ears, Nose, and Throat:			Gastrointestinal:		
Genitourinary:			Hematology:		
Infectious Disease:			Musculoskeletal:		
Neurologic:			Ophthalmology:		
Psychiatric/Psychological:			Renal:		
Respiratory:			Skin:		
Neurodevelopmental:			Behavioral:		

MEDICATIONS & TREATMENTS

Medication name	Form	Dose	Time of day	Reason	Route (by mouth unless noted). Other comments:

Last reconciled:	
Special medication instructions:	
Treatment Plan:	
Medication	

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History:	
Allergies:	
Diet:	
Current Equipment:	
Equipment Needs:	

PROFESSIONALS & SERVICES

Primary care clinician:		Phone:		Fax:			
Non-clinician contact:		Phone:		Email:		Last visit:	
Street Address:	City:	State:	Zip:	Practice:			
Preferred pharmacy:		Phone:		Fax:			
Preferred hospital:		Phone:		Fax:			

OTHER PROVIDERS	NAME/TYPE/LOCATION	LAST VISIT	REASON FOR SERVICE	CONTACT INFORMATION
Specialist 1:				
Specialist 2:				
Specialist 3:				
Specialist 4:				
Psych / Behavior:				
Dentist:				
Vision:				
Therapy (OT/PT/etc.):				
Hearing:				
Home Care:				
Community agency:				
Government services:				
Waiver/Other case manager:				
Equipment/Vendor:				

IMMUNIZATIONS

DTaP/DTP/TD								
OPV/IPV					HPV			
MMR			Varicella			Hep A		
Hep B				Meningococcus				
PPD				Pneumovax				
Flu								
HIB				Rotovirus		Tdap		

FAMILY MEDICAL HISTORY

Condition	Who?	Condition	Who?	Condition	Who?
Coronary Artery Disease:		Hypertension:		Diabetes:	

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Mental Health:		Cancer Type:		Genetic:	
Neurodevelopmental:		Lipids:		Other:	

NOTES:

HOSPITALIZATIONS (date, reason, location if known)

SURGERIES (date, reason, location if known)

PROCEDURES (labs, imaging, etc.)

DIAGNOSIS SPECIFIC MONITORING

ABOUT MY FAMILY

Race/Ethnicity:	
Unique family attributes:	
Family description of health condition:	
Family's support "system"	
Family life stressors:	
Housing:	☐ Own ☐ Rent
Emergency exit plan (fire, tornado, etc.):	
Transportation access/safety:	
Caregivers' occupations:	
Family financial concerns:	

SCHOOL

Current setting:	First Steps:		Head Start:		Preschool:
	K-12; Grade:		Homeschooled:		Other:
Current school name:			Current School District:		
Primary Contact:	☐ Classroom teacher		☐ Teacher of Record		☐ Other:
Contact name:		Contact Email:		Contact Phone:	
Previous setting:	First Steps:		Head Start:		Preschool:
	K-12; Grade:		Homeschooled:		Other:
Previous school name:			Previous School District:		

Services: ☐ Has a 504 Plan ☐ Has an individualized education plan (IEP/IFSP) ☐ Behavioral Intervention Plan ☐ Response to intervention (RTI)

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	☐ Gifted services ☐ Other:	☐ Physical therapy (PT)	☐ Occupational therapy (OT)	☐ Speech

Educational History:

CHILDCARE

Childcare type:	☐ Full-time	☐ Part-time	☐ In-home	☐ Center-based	☐ Voucher supported	☐ Respite only
Primary contact:	☐ Classroom teacher		☐ Director		☐ Other:	
Contact name:		Contact Email:		Contact Phone:		

NOTES / OTHER

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Plan of Care: Negotiated Actions

Prioritized Goals	Action Items/strategies (To reach short term goals)	Person responsible	Target date	Resolved (Date)
Family Personal Goals & Priorities				
Collaboration with/request from primary care and community				
Clinical Goals & Priorities				
Collaboration with/request from primary care and community				
Parking Lot/Future Goals				

Family Signature:

Date:

Clinician Signature:

Date:

Care Coordinator Signature:
Date:
Care Coordinator Name:
Phone:
Email: