Hospital Name

Address: _____

City, State, Zip Code: _____ Website: _____

Phone Numbers:

Main Number: _____ Emergency Room: _____

Medical Record Number: _____

- Clinic: _____ Hours/Days of Operation: _____

  Physician: _____

  Contact Person / Title: _____

  Phone: _____ Fax: _____ Email: _____

- Clinic: _____ Hours/Days of Operation: _____

  Physician: _____

  Contact Person / Title: _____

  Phone: _____ Fax: _____ Email: _____

- Clinic: _____ Hours/Days of Operation: _____

  Physician: _____

  Contact Person / Title: _____

  Phone: _____ Fax: _____ Email: _____

Medical / Dental
Community Health Care Providers

- Primary / Community Care Provider: _____

Office Nurse: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Community Hospital: _____

Medical Record Number: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Community Specialty Care Provider: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Community Specialty Care Provider: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Dentist / Orthodontist: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Home Care
Community Health Care / Service Providers

- Home Nursing Agency: _____

Start Date: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Home Nursing Agency: _____

Start Date: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Home Nursing Agency: _____

Start Date: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Therapists
Community Health Care / Service Providers

Therapists:

- Occupational Therapist (OT) _____

Start Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

- Physical Therapist (PT): _____

Start Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

- Speech-Language Pathologist: _____

Start Date: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Pharmacy
Community Health Care / Service Providers

- Pharmacy: _____ Hours/Days of Operation: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Pharmacy: _____ Hours/Days of Operation: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Pharmacy: _____ Hours/Days of Operation: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Special Transportation
Community Health Care / Service Providers

- Transportation (to and from medical / therapy appointments)

Contact Person: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

- Transportation (to and from medical / therapy appointments)

Contact Person: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Family Information

- Your Name: _____ Nickname: _____
  Date of Birth: _____
  Diagnosis: _____
  Blood Type: _____

  Legal Guardian: _____
  Address: _____
  Phone: _____

Family Members

- Mother's Name: _____
  Address: _____ Email: _____
  Daytime Phone:_____ Evening Phone:_____ Cell: _____

- Father's Name: _____
  Address: _____ Email: _____
  Daytime Phone:_____ Evening Phone:_____ Cell: _____

- Sibling's Name: _____ Age: _____ Name: _____ Age: _____
  Name: _____ Age: _____ Name: _____ Age: _____

- Other Household Members: _____

- Important Family Information: _____

- Language Spoken at Home: _____
  Other Language(s): _____
  Interpreter Needed? Yes: ☐ No: ☐
  Interpreter: _____ Phone: _____

Emergency Contact

- Name: _____
  Address: _____ Email: _____
  Daytime Phone:_____ Evening Phone:_____ Cell: _____

Insurance/Funding Sources

- Insurance Company: _____

  Policy Number: _____

  Contact Person / Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

- Insurance Company: _____

  Policy Number: _____

  Contact Person / Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

- Insurance Company: _____

  Policy Number: _____

  Contact Person / Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

- Supplemental Security Income (SSI): _____

  Contact Person / Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

(continued)

Insurance/Funding Sources

- Other: _____

  Contact Person/Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

- Other: _____

  Contact Person/Title: _____

  Address: _____

  Phone: _____ Fax: _____ Email: _____

  Website: _____

Care Schedule

TIME	CARE
Morning	
Afternoon	

Care Schedule

TIME	CARE
Evening	
Night	

Appointment Log

DATE	PROVIDER	REASON FOR APPOINTMENT / CARE PROVIDED	NEXT APPOINTMENT

Medical / Surgical Procedures

DATE	PROCEDURE	RESULTS	COMMENTS

Lab Work / Tests / Procedures

DATE	TEST	RESULTS	COMMENTS

Equipment / Supplies

- Name of Equipment: ____________________

  Description (brand name, model, size, etc.): ____________________

Date obtained: ____________ Supplier: ____________________

Website: ____________________

Contact Person: ____________________ Phone: ____________

Serial Number: ____________________

- Name of Equipment: ____________________

  Description (brand name, model, size, etc.): ____________________

Date obtained: ____________ Supplier: ____________________

Website: ____________________

Contact Person: ____________________ Phone: ____________

Serial Number: ____________________

- Name of Equipment: ____________________

  Description (brand name, model, size, etc.): ____________________

Date obtained: ____________ Supplier: ____________________

Website: ____________________

Contact Person: ____________________ Phone: ____________

Serial Number: ____________________

- Name of Equipment: ____________________

  Description (brand name, model, size, etc.): ____________________

Date obtained: ____________ Supplier: ____________________

Website: ____________________

Contact Person: ____________________ Phone: ____________

Serial Number: ____________________

Medications

Allergies:

Pharmacy: Phone:

MEDICATION	DATE STARTED	DATE STOPPED	DOSE / ROUTE (with or without food?)	TIME GIVEN	PRESCRIBED BY

Diet
Tracking Form

DATE	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

Hospital Stay Tracking Form

DATE	HOSPITAL	REASON	NOTES

Medical Bill Tracking Form

DATE	PROVIDER	COST	INSURANCE PAID	DATE PAID	FAMILY OWES	DATE PAID

“MAKE-A-CALENDAR” Month Year

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Notes

Getting to Know Me

Name:	**Nickname:**
Date of Birth:	**Today's Date:**

Who am I? How would I describe myself?

What are my strengths/interests?

What is my life like in the community?
(Things to consider: school, favorite places)

How would I describe my family situation?
(Things to consider: siblings, parents, other relatives, pets, where you call home)

What is my diagnosis (diagnoses) and what that means for me?
(Things to consider: doctor's explanation, my explanation)

What are my challenges?
(Things to consider: things that frustrate me about my illness, how people interact with me due to my illness)

What do I think of my overall health?
(Things to consider: limitations, things that bother me, things I can control)

What are my prior surgeries, procedures, lab/diagnostic studies?

Date:	Procedure:	Results:

What are my current medicines/doses?

What are my allergies?
What are things to avoid? *(Things to consider: food, procedures, activities such as gym class, etc.)*
What Equipment/Assistive Technology do I need?
Braces/orthotics ☐ Walker, wheelchair ☐ Communication device ☐ Home O_2 ☐ Insulin pump ☐ Nebulizer ☐ Suction ☐ Other:
What other things I'd like you to know about me and my condition:
How do I want information: *(Things to consider: tell me in writing, tell me alone, or tell me and my parents together)*
Things I want help with:
Boundaries:
My responses to my illness: *(Things to consider: general responses, tired, excited, hungry)*
How I want to be treated:
☐ It's OK to ask me if I need help. ☐ It's **not** OK to ask me if I need help ☐ It's OK to ask me details about my condition ☐ It's **not** OK to ask me details about my condition

Emergency Information for:

Name: _____

Today's Date (mm/dd/yy): _____

Birth Date (mm/dd/yy): _____

Primary Language: _____

Address: _____

Parents/Guardians

_____

_____

Phone Numbers

H: _____
W: _____
C: _____

H: _____
W: _____
C: _____

Diagnosis

Diagnosis:

_____

_____

_____

Medications: Dose Time

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

Emergency Contact – Relationship/Phone#

_____

Doctor's Information

Main Doctor: _____
Phone: _____ Fax: _____

Specialty Doctor: _____
Phone: _____ Fax: _____

Specialty Doctor: _____
Phone: _____ Fax: _____

Hospital: _____
Phone: _____ ER: _____

Pharmacy: _____
Phone: _____

Insurance:

_____

_____

_____

_____

Most Important Things to Know About Me in an Emergency

_____

_____

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Copies of this form are available at http://cshcn.org

Directions:

1. Fill in and/or print form
2. If you have Acrobat Reader 8.0 or higher, you may save this PDF for future edits (visit Adobe's site to download the newest version of Acrobat Reader)
3. Cut on heavy dashed lines
4. Fold on dotted lines to fit in wallet

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Center for Children with Special Needs
www.cshcn.org

Washington State Department of Health

What's the Plan?

Name:	Date of Birth:	Provider:
Parent's Name:		Today's Date:

What do I want to talk about today?

Specifics today
- What's new?
- How have I been feeling?
- Worries down the road?
- What am I planning before the next visit or in the near future?

What do I hope to have happen?

- Today
- From the doctor
- For me to do

Next steps? What needs to be done?

- Labs
- Change medicine
- Check insurance

Who will do this?

- Me
- Parents
- Doctors
- Nurse

By when? (time frame)

- Immediate
- 1 month
- 6 months
- 1 year

If I think of anything else later, who do I call?

- Questions
- New appointments
- Email Addresses

For additional copies of this form and more, please visit http://www.cshcn.org

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Center for Children with Special Needs
www.cshcn.org
Washington State Department of Health