DCF-2102 **State of Connecticut**

08/2013 (Rev.) **Department of Children and Families** Page 1 of 2

# DISCHARGE PLAN FOR CHILD WITH COMPLEX MEDICAL NEEDS

|  |  |  |  |  |  |  |  |  |
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| Child’s Name | | | Link Number | | | Date of Birth | | |
| Diagnosis | | | | | | | | |
| Foster Parent Name | | | | | | Telephone | | |
| Address | | | | | | | | |
| DCF Social Worker | | | | | | Telephone | | |
| DCF Area Office | | | | | | | | |
| Primary Health Care Provider | | | | | | Telephone | | |
|  | | | | | | | | |
| **Medical Needs and Equipment** | | | | | | | | |
| Continuous O2 | | | | | Apnea Monitor | | Wheelchair | |
| Intermittent O2 | | | | | Sidelyer | | Stander | |
| Tracheostomy Care | | | | | Suctioning | | Nasogastric Tube | |
| Ventilator | Length of Time: | | | | Nebulizer | | Gastrostomy Tube | |
| Continuous Positive Airway Pressure | | Length of Time: | | | | | Other: | |
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| **ALLERGIES (List):** | | | | | | | | |
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| **Current Medications:** | | | | | | | | |
| **Prescription/Non-Prescription:** | | | | **Dosage** | | | | **Frequency** |
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| **Immunizations: (During Hospitalization)** | | | | | | | | |
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| **Special Diet:** | | | | | | | | |
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**Discharge Plan** Page 2 of 2, DCF-2102

Child's Name

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| **Educational Needs:** | | | |
| **At-home services:** | | | |
| **Service** | **Frequency** | **Location** | |
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| **Out-of-home services:** | | | |
| **Service** | **Frequency** | **Who Provides Transportation** | **Location** |
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| **Therapy Needs:** | **Frequency** | **Location** |
| PT |  |  |
| OT |  |  |
| Speech |  |  |
| Other: |  |  |

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| **Developmental Delay:** | |
| Yes | No |
| If yes, explain: | |

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| **Physical Environment:** | | | | |
| **Handicapped Access:** | | | | |
| Bathroom | Hallways | Outside ramp | Vehicle/wheelchair accessible | Generator |
| Other: (specify) | | | | |

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| **Home Care Services:** | |
| **Agency:** | **Telephone:** |
| **Services Ordered:** | |

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| **FOLLOW-UP APPOINTMENTS:** | | | |
| **Health Care Provide Name** | **Specialty** | **Telephone** | **Appointment Date** |
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| **ADDITIONAL COMMENTS:** |

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| SIGNATURES: |

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| --- | --- | --- |
| Person Completing this Form: | Title: | Date: |
| DCF Social Worker: | | Date: |
| Reviewed by RRG Nurse: | | Date: |
| Approved by Area Office Behavioral Health PD: | | Date: |