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

|  |  |  |
| --- | --- | --- |
| 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:       |
|  |
| **[ ]  ALLERGIES (List):** |
|       |
|  |
| **[ ]  Current Medications:** |
| **Prescription/Non-Prescription:** | **Dosage** | **Frequency** |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |
| **Immunizations: (During Hospitalization)** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
| **[ ]  Special Diet:** |
|       |

 **Discharge Plan** Page 2 of 2, DCF-2102

Child's Name

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

|  |
| --- |
| **[ ]  Developmental Delay:** |
| [ ]  Yes | [ ]  No |
| If yes, explain:       |

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

|  |
| --- |
| **[ ]  Home Care Services:** |
| **Agency:**       | **Telephone:**       |
| **Services Ordered:**       |

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

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| [ ]  SIGNATURES: |

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