|  |  |
| --- | --- |
|  | **HEALTH SUMMARY** |

|  |  |  |  |
| --- | --- | --- | --- |
| Case Name |       | Case ID # |       |
| Child/Youth |       | Child ID # |       |
| Child's Age |       | Child's D.O.B. |       | Primary Language |       |
| Emergency Contact Name& Relationship |       | Phone |       |
|       | Phone |       |
|  |
| **Current Health Care Providers** |
| **Provider Type** | **Name** | **Phone** | **Last Exam/Visit** |
| Primary Care Medical Provider |       |       |       |
| Dentist |       |       |       |
| Mental/ Behavioral Health Professional | Psychiatrist |       |       |       |
| Therapist |       |       |       |
| Medical Provider | Specialist |       |       |       |
| Specialist |       |       |       |
| Specialist |       |       |       |
| **Attach Most Current Immunization Records** |
| **Complex Medical Needs** | CLASSIFICATION |  |
| [ ]  Yes [ ]  No | If Yes, Level | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |  |
| **Diagnoses Acute/Chronic – Past Procedures – Physical Exams** |
| 1.       |  | Baseline Physical Findings:       |
|       |  |       |
| 2.       |  |       |
|       |  |       |
| 3.       |  | Baseline Vital Signs:       |
|       |  |       |
| 4.       |  |       |
|       |  |       |
| Synopsis:       |  | Baseline Neurological Status:       |
|       |  |       |
|       |  |       |

|  |  |  |
| --- | --- | --- |
| **Allergies Epi Pen:** **[ ]  Yes** **[ ]  No** |  |  |
| Medication/Foods to be Avoided: |  | Associated Adverse Reactions: |
| 1.       |  |       |
| 2.       |  |       |
| 3.       |  |       |
| Procedures to be Avoided: |  | and Why: |
| 1.       |  |       |
| 2.       |  |       |
| 3.       |  |       |
| **Common Presenting Problems/Findings with Specific Suggested Managements** |
| Problem: |  | Suggested Diagnostic Studies: |  | Treatment Considerations: |
|       |  |       |  |       |
|       |  |       |  |       |
|       |  |       |  |       |
|       |  |       |  |       |
| **Medications (Current)** |  |  |  |  |  | Date Started: |  |  |
|  | Dose: |  | Prescriber: |  |  | Purpose: |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
| **Special Equipment/Dietary Needs** (glasses, hearing aids, nebulizer, diabetic supplies, formula type, etc.) |
|       |
|       |
|       |
|       |
| **Comments on Child, Family, or Other Specific Medical Issues** |
|       |
|       |
|       |
|       |

|  |  |
| --- | --- |
| Completed by:       | Date:       |