Name: DOB:

Transition Care Plan

Current Care Team Members (Name/ Telephone)

Adult Care Team Members: (Name/Telephone)

PMD:	PMD:
Specialty Provider:	Specialty Provider:
Transition Coordinator:	
Social Worker:	Other:
Other	Other:

Contacts (name, phone numbers, e-mail):

Parents / Guardian/ Power of Attorney:

Preferred Patient Communication method: (drop down)

non-verbal verbal written parent/guardian other

Dropdown: Sign Language, communication device, eye blink, picture cards, other*** **Cognitive** ***

Pt._____is a (*** year old male/female) who has been diagnosed with ***. He/she resides ***.....He/she is enrolled in school *** and or employed part/full time *** He/she is involved in or participates in ****Pt.'s support system includes ***.....His/her goals are ***.....

Language/Culture

Language spoken in the home: *** Interpreter needed: yes*** no Religion: *** Special cultural/religious beliefs or needs identified: ***

Patient Medical History/Family Goals (psychosocial, spiritual) *** Family History: Social History:

Medical Self Management (drop down)

Independent in cares Dependent in cares Parent/guardian involvement in cares***

Code Status: (drop down) Advance Directive yes no Discussed with family

Past Medical History***

Name: DOB:

Surgical History: *** Active Problem/Emergency Plan ***

Problem	Suggested Diagnostics	Plan or Treatment	Responsible	Outcome/Goal

Pertinent Positives from Physical Exams:

HT:	Wt:	T:	P:	R:	Pulse Ox:	Blood Pressure:
Gene	ral:					
Neuro	ological:					
HEEN	IT:					
Cardia	ac:					
Respi	ratory:					
Abdo	men:					
GU:						
Musc	uloskele	tal:				
Skin:						
Menta	al Statu	S:				

Pertinent Laboratory Findings

Test	Result	Date

Pertinent Imaging Findings

Test	Result	Date

Pertinent Diagnostic Studies

Study	Finding	Date

Future Recommended Lab/Imaging/Appointments ***

Medical / Assistive Technology Supports

Drawn in from doc flow sheets as much as possible:

Vent settings: Trach care: Oxygen requirements: Lines, Drains, Airways: Other: *** Comment: ***

Medical /Assistive Equipment Supports/DME

Basic list of equipment ***

Clinical Summary	Name:
Date of Service:	DOB:
MR#	

Allergies:

Allergen	HX of Reaction (Drop down y/n)	Type of Reaction ***	Epi- Pen?
			y/n

Immunizations:

Current Medications

Name	Concentration	Dose	Schedule	Purpose	Prescribed by	Start date

Comment***

Current Enteral Nutrition***

Route: (PO, GT, GJ, JT) Type and size of tube: Type and amount of formula: Feeding Schedule: Comments: (Venting, Refeeding, special dietary needs, etc.) Other: *** Comments: *** **Current Parenteral Nutrition *****

Current Therapies (drop down)

Physical therapy

Occupational therapy

Speech therapy

Mental health

🔲 Other

Comment: ***

<u>Current Functional Status (drop down):</u> Cognitive ***

Behavioral/Mental Health (drop down):

ADD/ADHD, Aggression, Anxiety, Autism, Bi-polar disorder, Depression, OCD, other*** Comment ***

Mobility

- No issues
- Non-ambulatory
- Walker
- Power W/C
- Manual W/C
- Able to transfer

Name: DOB:

- Unable to transfer
- Transfer with assist
- Transfer with Hoyer lift
- Other***

Vision

- Normal vision both eyes
- Normal vision one eye only
- Vision impairment fully corrected with lenses
- Vision impairment not fully corrected with lenses
- Cortical visual impairment
- Legal blindness

Comment***

Hearing (drop down)

- No hearing impairment
- Hearing impairment with no adaptive device used
- Hearing impairment with use of adaptive device (Drop down):

hearing aids, cochlear implant, FM unit in school, etc)

- Profound deafness- communicates by***
- Comment***

Bowel Function

Independent

- Minimal assist
- Dependent
- Incontinent ***
- Continent
- Cecostomy
- Other***

Bladder Function

- Independent
- Minimal assist
- Dependent
- Continent
- Incontinent
- Clean Intermittent Catheterization
- Vesicostomy
- Other***

Reproductive Health / Sexuality Issues (drop down: "discussed - not discussed"):

- Relationship status***
- Sexually active
- Sexual orientation
- STI

Name: DOB:

- Fertility
- Pregnancy prevention
- Concerns about exploitation
- Assessment of sexual knowledge
- Sexual functioning
- Impact of condition on physical development
- Genetic implications on reproduction
- Community resources
- Other***
- Comment***

Education School: *** Type (drop down): Graduated from high school Attending high school transition program Attending college 2 year

Technical 4 year CD program

Grade level in school: *** Extracurricular activities: ***

Educational Needs/Performance:

□ N/A

- Patient is enrolled in homebound program or online school program
- Patient is enrolled in regular education classes
- Patient has an IEP/504 Plan
- There are no attendance or academic concerns noted at this time
- There are academic concerns
- There are attendance concerns

Comment: ***

Employment

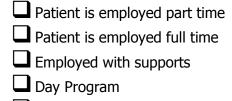
N/A

Patient is unemployed

Patient is pursuing employment

Patient is working with DVR

Name: DOB:



Workforce training program

Comment: ***

Transition Issues: ***

Community Providers/Resources: (drop down ***)

- County social worker/liaison:
- Employer/supervisor:
- Dept of Vocational Rehabilitation (DVR) worker:
- School:
- Landlord:
- Transportation Company:
- Home Nursing:
- DME Supplier:
- Infusion Company:
- Pharmacy:
- Therapies:
- Other:

Prepared by:

Time Spent: