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

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***

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:
General:
Neurological:
HEENT:
Cardiac:
Respiratory:
Abdomen:
GU:
Musculoskeletal:
Skin:
Mental Status:

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
***

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: ***

Current Functional Status (drop down):
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

- 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

- 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

- ❑ Patient is employed part time
- ❑ Patient is employed full time
- ❑ Employed with supports
- ❑ Day Program
- ❑ 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:**