Click here to enter text.

**Pediatric Care Plan for Children with Special Healthcare Needs**

**Last updated:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information:** | | | | | | | | | |
| **Complexity Level**: Choose one  **Insurance:** Insurance Policy **Chart Number:** Number | | | | | | | | | |
| **Patient Name:** Name.  **Date of Birth:** DOB.  **Parent:** Name.  **Relationship:** Choose an item.  **Phone:** Phone. | | | | | | | | | |
| **Educational Information:** | | | | | | | | | |
| **School Information:** Choose an item.  **School Name:** Click here to enter text.  **Grade:** Choose an item.  **Person of contact:** Click here to enter text. **Phone:** Click here to enter text. | | | | | | | | | |
| **Challenges:** | **Equipment Needs/Assistive Technologies:** | | | | **Special Clinical Accommodations:** | | | | |
| Behavioral   Learning   Physical Anomalies   Respiratory   Communication   Sensory  Orthopedic/Musculoskeletal   Feeding/Swallowing   Hearing/Vision   Stamina/Fatigue   Other: Click here to enter text. | Gastronomy   Adaptive Seating   Wheelchair   Orthotics   Stander/Walker  Crutches/Braces   Tracheostomy   Suction   Nebulizer  Communication Device   Hearing Aids/Cochlear  Monitors:  Apnea O2 Glucose Cardiac   Other: Enter text. | | | | Room immediately   Dim lighting   Low volume   Sensory toys  Minimize wait   Picture communication   Wheelchair access   Other: Click here to enter text. | | | | |
| **Chronic Condition Management:** | | | | | | | | | |
| **Problem List:** | | | | | | | | | |
| **Diagnosis** | | | | | | | | | **ICD-10 Code** |
| primary diagnosis. | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| Secondary diagnosis | | | | | | | | | ICD 10 code |
| **Treatment:** | | | | | | | | | |
| **Clinical Goals** | | | | **Specialist/Care Provider Responsible** | | | | **Follow-Up Date** | |
| Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | |
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| Click here to enter text. | | | | Click here to enter text. | | | | Click here to enter text. | |
| **Medications:** Choose an item. | | | | | | | | | |
| **Name** | | | **Dosage** | | | **Frequency** | | | |
| Click here to enter text. | | | Click here to enter text. | | | Click here to enter text. | | | |
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| Click here to enter text. | | | Click here to enter text. | | | Click here to enter text. | | | |
| **Allergies:** Choose an item. | | | | | | | | | |
| Click here to enter text. | | | | | | | | | |
| **Recent Labs:** Choose an item. | | | | | | | | | |
| **Type** | **Result** | | | | **Date** | | | | |
| Choose an item. | Click here to enter text. | | | | Click here to enter a date. | | | | |
| Choose an item. | Click here to enter text. | | | | Click here to enter a date. | | | | |
| Choose an item. | Click here to enter text. | | | | Click here to enter a date. | | | | |
| Choose an item. | Click here to enter text. | | | | Click here to enter a date. | | | | |
| **Care Team Information:** | | | | | | | | | |
| **Provider** | | **Location** | | **Phone** | | | **Fax** | | |
| **PCP:** Choose an item. | |  | |  | | |  | | |
| **Specialist:** Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | |
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| **Specialist:** Click here to enter text. | | Click here to enter text. | | Click here to enter text. | | | Click here to enter text. | | |
| **Home Nursing/Respite Care?**  Yes  No | | | | | | | | | |
| **If yes, organization & phone:** Click here to enter text. | | | | | | | | | |

