Click here to enter text.

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

**Last updated:**

|  |
| --- |
| **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. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 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. |
| 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. |
| 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. |

