

.....

# Hospital Name

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Website: \_\_\_\_\_

Phone Numbers:

Main Number: \_\_\_\_\_ Emergency Room: \_\_\_\_\_

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Medical Record Number: \_\_\_\_\_

• Clinic: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Physician: \_\_\_\_\_

Contact Person / Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

• Clinic: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Physician: \_\_\_\_\_

Contact Person / Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

• Clinic: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Physician: \_\_\_\_\_

Contact Person / Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

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# Medical / Dental Community Health Care Providers

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• Primary / Community Care Provider: \_\_\_\_\_  
Office Nurse: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Community Hospital: \_\_\_\_\_  
Medical Record Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Community Specialty Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Community Specialty Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Dentist / Orthodontist: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

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# Home Care

## Community Health Care / Service Providers

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• Home Nursing Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

• Home Nursing Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

• Home Nursing Agency: \_\_\_\_\_

Start Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

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# Therapists

## Community Health Care / Service Providers

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Therapists:

• Occupational Therapist (OT) \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

• Physical Therapist (PT): \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

• Speech-Language Pathologist: \_\_\_\_\_

Start Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

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# Pharmacy

## Community Health Care / Service Providers

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• Pharmacy: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

• Pharmacy: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

• Pharmacy: \_\_\_\_\_ Hours/Days of Operation: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

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# Special Transportation Community Health Care / Service Providers

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- Transportation (to and from medical / therapy appointments)

Contact Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

- Transportation (to and from medical / therapy appointments)

Contact Person: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

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# Family Information

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- Your Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Blood Type: \_\_\_\_\_  
Legal Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

## Family Members

- Mother's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell: \_\_\_\_\_
- Father's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell: \_\_\_\_\_
- Sibling's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_
- Other Household Members: \_\_\_\_\_
- Important Family Information: \_\_\_\_\_
- Language Spoken at Home: \_\_\_\_\_  
Other Language(s): \_\_\_\_\_  
Interpreter Needed? Yes:  No:   
Interpreter: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Contact

- Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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# Insurance/Funding Sources

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• Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Supplemental Security Income (SSI): \_\_\_\_\_  
Contact Person / Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

(continued)



# Insurance/Funding Sources

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• Other: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

• Other: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Website: \_\_\_\_\_

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# Care Schedule

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TIME	CARE
Morning	

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# Care Schedule

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TIME	CARE
Evening	
Night	







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# Equipment / Supplies

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• Name of Equipment: \_\_\_\_\_

Description (brand name, model, size, etc.): \_\_\_\_\_

Date obtained: \_\_\_\_\_ Supplier: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Serial Number: \_\_\_\_\_

• Name of Equipment: \_\_\_\_\_

Description (brand name, model, size, etc.): \_\_\_\_\_

Date obtained: \_\_\_\_\_ Supplier: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Serial Number: \_\_\_\_\_

• Name of Equipment: \_\_\_\_\_

Description (brand name, model, size, etc.): \_\_\_\_\_

Date obtained: \_\_\_\_\_ Supplier: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Serial Number: \_\_\_\_\_

• Name of Equipment: \_\_\_\_\_

Description (brand name, model, size, etc.): \_\_\_\_\_

Date obtained: \_\_\_\_\_ Supplier: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Serial Number: \_\_\_\_\_

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# Diet Tracking Form

DATE	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							







# ‘MAKE-A-CALENDAR’

Month

Year

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# Notes



# Getting to Know Me

<b>Name:</b>	<b>Nickname:</b>
<b>Date of Birth:</b>	<b>Today's Date:</b>
<b>Who am I? How would I describe myself?</b>	
<b>What are my strengths/interests?</b>	
<b>What is my life like in the community?</b> <i>(Things to consider: school, favorite places)</i>	
<b>How would I describe my family situation?</b> <i>(Things to consider: siblings, parents, other relatives, pets, where you call home)</i>	
<b>What is my diagnosis (diagnoses) and what that means for me?</b> <i>(Things to consider: doctor's explanation, my explanation)</i>	
<b>What are my challenges?</b> <i>(Things to consider: things that frustrate me about my illness, how people interact with me due to my illness)</i>	
<b>What do I think of my overall health?</b> <i>(Things to consider: limitations, things that bother me, things I can control)</i>	
<b>What are my prior surgeries, procedures, lab/diagnostic studies?</b>	
Date:	Procedure: Results:
<b>What are my current medicines/doses?</b>	

**What are my allergies?**

**What are things to avoid?**

*(Things to consider: food, procedures, activities such as gym class, etc.)*

**What Equipment/Assistive Technology do I need?**

Braces/orthotics  Walker, wheelchair  Communication device  Home O<sub>2</sub>   
Insulin pump  Nebulizer  Suction  Other:

**What other things I'd like you to know about me and my condition:**

**How do I want information:**

*(Things to consider: tell me in writing, tell me alone, or tell me and my parents together)*

**Things I want help with:**

**Boundaries:**

**My responses to my illness:**

*(Things to consider: general responses, tired, excited, hungry)*

**How I want to be treated:**

- It's OK to ask me if I need help.
- It's **not** OK to ask me if I need help
- It's OK to ask me details about my condition
- It's **not** OK to ask me details about my condition



**Seattle Children's**  
HOSPITAL • RESEARCH • FOUNDATION

Center for Children  
with Special Needs  
www.cshcn.org





# What's the Plan?

<b>Name:</b>	<b>Date of Birth:</b>	<b>Provider:</b>
<b>Parent's Name:</b>		<b>Today's Date:</b>
<b>What do I want to talk about today?</b>		
Specifics today <ul style="list-style-type: none"> <li>• What's new?</li> <li>• How have I been feeling?</li> <li>• Worries down the road?</li> <li>• What am I planning before the next visit or in the near future?</li> </ul>		
<b>What do I hope to have happen?</b>		
<ul style="list-style-type: none"> <li>• Today</li> <li>• From the doctor</li> <li>• For me to do</li> </ul>		
<b>Next steps? What needs to be done?</b>		
<ul style="list-style-type: none"> <li>• Labs</li> <li>• Change medicine</li> <li>• Check insurance</li> </ul>		
<b>Who will do this?</b>		
<ul style="list-style-type: none"> <li>• Me</li> <li>• Parents</li> <li>• Doctors</li> <li>• Nurse</li> </ul>		
<b>By when? (time frame)</b>		
<ul style="list-style-type: none"> <li>• Immediate</li> <li>• 1 month</li> <li>• 6 months</li> <li>• 1 year</li> </ul>		
<b>If I think of anything else later, who do I call?</b>		
<ul style="list-style-type: none"> <li>• Questions</li> <li>• New appointments</li> <li>• Email Addresses</li> </ul>		

For additional copies of this form and more, please visit <http://www.cshcn.org>