***All about Me***

My name is:

First Middle Last

My nickname is:

I live at:

The names of the people in my family are

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| --- | --- | --- |
| First | Last | Relationship to me |
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Other people who know me well are (friends, babysitter, neighbors, etc.)

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| First | Last | Relationship to me |
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**My Pets**

My Pet is a Name of Pet

My other pet is a Name of Pet

**Things I like to do during my free time**

**My “Favorites”**

Toys

Games

Hobbies

Songs

TV Shows

Other

Foods I like are:

Foods I don’t like are:

I usually go to bed at o’clock.

Before bed, I usually:

**Things I need help with are (for example: washing up, brushing teeth, dressing, etc.)**

**Things I can do myself are**

Medical Home Appointment Focus Sheet

**Parent/Family Needs:**

*I have questions or concerns about: (check all that apply)*

* My child’s Health/Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medicines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Specialists/Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lab Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* School/IEP’s/Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Money/Finances/Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Behavior problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Toilet Training\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Community Based Services (Early Intervention, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Home Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Family Needs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Transitions/Life changes: new school, Sexuality/Maturation, what do I do when I grow up? Etc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Things I want to talk about with my Doctor this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Needs for this Visit:**

Issues I would like to follow up on, or discuss with patient and family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Items need for this visit:

* **Lab results/Referral results needed and not in chart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Website information/Parent Handouts needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Reason for calling for appointment:** (chief complaint) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Follow Up:**
  + **Call (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Next Visit (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Next Visit Agenda \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Treatment Care Plan:**

**Child Will: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Will:**

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**Physician’s Office Will:**

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| **Getting to Know My Child** |
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| **ACTIVITIES OF DAILY LIVING** |
| Describe your child’s abilities to feed him or herself, bathe, get dressed, use the bathroom, comb hair, brush teeth, etc., including any special routines your child has for these activities. Describe what your child can do by him or herself and any help or equipment your child uses for these activities. |
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| **MOBILITY** |
| Describe your child’s abilities to feed him or herself, bathe, get dressed, use the bathroom, comb hair, brush teeth, etc., including any special routines your child has for these activities. Describe what your child can do by him or herself and any help or equipment your child uses for these activities. |
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| **COMMUNICATION** |
| Describe your child’s ability to communicate and to understand others. Include sign language, words, gestures, or any equipment or help your child uses to communicate or understand others. Include any special words your family and child use to describe things. |
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| **REST/SLEEP** |
| Describe your child’s ability to get to sleep through the night. Describe your child’s bedtime routine and any security or comfort objects your child uses. |
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| **EMOTION** |
| Describe how your child shows affection, shares feelings, or plays with other children. What works best to get your child to get along or cooperate with others? Describe your child’s favorite things to do. Include any special family activities or customs. |
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| **COPING/STRESS TOLERANCE** |
| What things upset your child? Stressful events might include new people or situations, a hospital stay, or procedures such as having blood drawn. What does your child do when upset or when he or she has “had enough.” Describe your child’s way of asking for help and things to do or say to comfort your child. |
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| **RESPIRATORY** |
| Describe your child’s respiratory (breathing) needs including care or treatments that your child needs and any special techniques or precautions you use when giving care. Include any special routines your child has for respiratory care |
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| **NOW AND LATER** |
| Record your child’s words and thoughts about his or her life now as well as in the future. What does your child do well now? What does your child want to be when he or she grows up? |
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| **OTHER INFORMATION** |
| Include here any additional information that is important about your child. |
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**Important Phone Numbers**

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| FAMILY INFORMATION | | | |
| Parent 1 | | **Parent 2** | |
| Name |  | Name |  |
| Address |  | Address |  |
|  |  |
| Cell  Home Phone |  | Cell  Home Phone |  |
| Work Phone |  | Work Phone |  |

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| Relatives | Phone Number | Relationship |
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| School | Phone Number |
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| MEDICAL SERVICES | | | |
|  | | **Phone Number** | |
| Paramedics | |  | |
| Emergency | |  | |
| Non-Emergency | |  | |
| Doctor Name | **Phone** | **Doctor Name** | **Phone** |
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| Therapy | | **Phone** | |
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| Hospitals | **Phone Number** |
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| Pharmacy | **Phone Number** |
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| --- | --- |
| Utility Companies | Phone Number |
| Gas: |  |
| Electricity: |  |
| Water: |  |
| \* Contact Utility Company for Medical Necessity Form | |

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| Other | Phone Number |
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**Child’s Name**: **DOB**:

**Problem / Treatment / History Log**

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| --- | --- | --- | --- | --- |
| Date | Problem  (Illness, injury, procedure (x-rays/labs), hospitalization (in-out-patient, ER), or office visit (dental, medical specialty). | Attending Physician | Location | Results/ Outcomes |
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**My Doctor Visits / Tests / Procedures**

**Tracking Sheet**

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| Date | Seen By | Changes Made / Updates |
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Keeping track of diagnosis can help new doctors if there are new symptoms.

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| **Diagnosis**:  Abbreviation:  Also called:  Doctor(s) who diagnosed:  Specialty of doctor(s):  Date(s) diagnosed: |
| **Diagnosis**:  Abbreviation:  Also called:  Doctor(s) who diagnosed:  Specialty of doctor(s):  Date(s) diagnosed: |
| **Diagnosis**:  Abbreviation:  Also called:  Doctor(s) who diagnosed:  Specialty of doctor(s):  Date(s) diagnosed: |
| **Diagnosis**:  Abbreviation:  Also called:  Doctor(s) who diagnosed:  Specialty of doctor(s):  Date(s) diagnosed: |
| **Diagnosis**:  Abbreviation:  Also called:  Doctor(s) who diagnosed:  Specialty of doctor(s):  Date(s) diagnosed: |

**Medication Summary Sheet**

Name: Birthdate:

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| NAME OF MED | Dosage | Time of day to be given | Start Date | End Date | Reason for giving | Ordered by | Additional notes – possible/observed side effects |
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**TRACKING OF MEDICAL BILLS**

If you have multiple insurances or are using Medicaid (Katie Beckett) and private insurance, this tracker can be helpful

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Service** | **Provider (hospital, doctor’s office, etc.)** | **Service (tests, surgery, etc.)** | **Cost** | **Who- Insurance or Medicaid Paid** | **Insurance Paid Amount** | **Date Paid** | **Family Owes** | **Date Paid** |
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| **tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work** | | | | |
| **Type of Test** | **Prescribed By** | **Date** | **Location of Test** | **Results** |
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**Medical Home Contacts**

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| TIP: Fill out this form and take it with you to visits with physicians and other specialists working with your child. (Be sure to include pediatrician or family doctor). You can ask that reports be sent to the persons listed on this form. This will save you time and effort when you are asked who will need copies of reports. | | | | | |
| Name | Specialty | Address | Phone Number | Dates Care Began | Dates Care Ended |
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**EMERGENCY ROOM VISITS**

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| --- | --- | --- | --- |
| DATE | HOSPITAL / MEDICAL FACILITY | HOSPITAL STAY?  (YES / NO) | RESULTS / COMMENTS |
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| **Medical Travel Expense Log** | | | | | |
| **DATE** | **TRAVEL FROM** | **TRAVEL TO** | **MILES** | **ADDITIONAL EXPENSES**  **(MEALS, LODGING, ETC.)** | **REASON FOR TRAVEL** |
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**TRACKING OF MEDICAL BILLS**

If you have multiple insurances or are using Medicaid (Katie Beckett) and private insurance, this tracker can be helpful

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| **Date of Service** | **Provider (hospital, doctor’s office, etc.)** | **Service (tests, surgery, etc.)** | **Cost** | **Who- Paid** | **Paid Amount** | **Date Paid** | **Family Owes** | **Date Paid** |
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| **tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work tests/x-rays/lab work** | | | | |
| **Type of Test** | **Prescribed By** | **Date** | **Location of Test** | **Results** |
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