MHLC

Medical Home Learning Collaborative

Comprehensive Care Planning

CMHI

NICHQ

National Initiative for Children's Healthcare Quality

Comprehensive Care Plan
Children with Special Health Care Needs

This folder contains information about the essentials of comprehensive care planning for children with special health care needs (CSHCN). Three distinct types of documents (present medical information plans, emergency plans, and working (action) care plans. When combined appropriately for CSHCN (based upon need), these tools make up a comprehensive care plan. A few of the care plan examples offer a combination of the three types of care plans (ie. an emergency plan and a medical information plan). These combined care plans are marked with an asterisk and will appear in both folders.

Table of Contents

MHLC
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Introduction to Essential Care Plan Components-

The Comprehensive Care Plan

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The Comprehensive Care Plan:
Medical Summary, Emergency Treatment Plan and
Working Care Plan
For Children with Special Health Care Needs

Children with special health care needs, their families, physicians, practice teams and community providers will benefit from having a clear, written medical summary, emergency treatment plan and plan of care. These components can be combined or developed separately. When combined the Medical Summary, Emergency Treatment Plan and Working Care Plan are the components of a Comprehensive Care Plan. The medical summaries, emergency treatment and care plans can be on paper, disk or if possible web-based. There are multiple purposes of the medical summary/care plans. These include:

- An available source of information for parents to provide to the medical, educational and other care teams,
- A quick reference with child-specific information in a medical emergency,
- An action plan that the entire care team, including the family and patient develop, use to prioritize, assign tasks, implement and assess care.

In the beginning remember that your practice team will decide who needs a medical summary or an emergency care plan depending on the complexity of the condition. The summary and/or emergency treatment plan will take some time to develop in the beginning, but the family, the clinicians and the community providers will find them very helpful. Your parent partners will be a great resource here with family friendly language.

The working care plan is a written framework combining the goals of the patient/family/team with the treatment plan. It is best to keep it simple at the start. Remember to start small with little steps. The Center for Medical Home Improvement Actionable Care Plan (working care plan) is a practical tool to get you started.

The major components of the comprehensive care plan include a medical summary with an emergency treatment plan and a working care plan:

1. **The Medical Summary:** The child's medical summary contains a short synopsis of the child's current diagnosis, problem list, treatment including medications and recurrent problems, past medical history and community based care. The specific components of the medical summary include:
   - Identifying and family contact (including emergency contact) information
   - Allergies and Medications
   - Diagnosis and Active Problem List (including critical equipment)
   - Consultants--Specialist and their contact information
   - Transport/Equipment Needs
   - Past History (Summary)
   - Review of Systems (Degree of current involvement)

- Coverage Concerns/Recurrent Problems
- Community Providers/Agencies
- Hospitalizations
- Assets and challenges unique to the individual child
- Other information the family wants caregivers to know about their child

Examples are available online at the AAP Medical Home website, the Center for Medical Home Improvement website, the PACC website (see links for these on the extranet), NICHQ Medical Home website, the EPIC-IC website and others.

2. **The Emergency Treatment Plan:** The medical summary can include information for emergency treatment and in many instances can serve as both the summary and the emergency plan. However, some parents and practices may want a separate Emergency Treatment Plan. The child with multiple, complex conditions and/or recurrent life threatening events may need an emergency treatment plan in addition to or in place of the medical summary. The AAP / ACEP emergency treatment plans are very similar to the medical summary and it would be duplicative to fill out both. The Emergency Treatment Plans do have more baseline physical/lab data. The AAP and the ACEP have approved them. The form is available on the AAP web site with links from the NICHQ website and others. (Some teams have found it helpful to use a medical summary and check of a box indicating an attached emergency plan).

3. **The Working Care Plan:** A care plan for a child with special health care needs can be as simple as a written, organized note developed during a visit, a more detailed plan of care developed during a meeting of the family, care coordinator and clinician or a comprehensive, integrated care plan developed by the child/family's multidisciplinary team. This plan helps direct the role/focus of the practice-based care coordinator. The critical components of the care plan include:
   - A prioritized list of main concerns/goals with
   - The current clinical/educational/social information pertinent to the concern/goal.
   - The current plan/intervention for that concern/goal
   - The person(s) responsible for that intervention
   - The due date for the intervention.

The working or action care plans are available on the NICHQ Medical Home web site, the AAP Medical Home web site and others.

Note: Some care planning examples combine two or more of the three components in the document. When this is the case an * indicates so in the table of contents for that documents.

Section One: Medical Information Care Plans

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MEDICAL SUMMARY - EPIC-IC

Date updated_____

Patient Name _____ **DOB** _____

Parent's Name_____**Phone(H)**_____**(W)**_____

Address_____ **E-mail**_____

Other Emergency Contact _____ **Phone**_____**Relationship**_____

Insurance _____

Principal Diagnosis_____ **PCP** _____

Secondary Diagnosis _____ **PCP Phone**_____

_____ **PCP Fax/E-mail**_____

Emergency Plan Yes___No___ Immunizations up-to-date Yes___No__Date_____

Allergies/Rxns (meds/foods/procedures)_____

Problem List (with critical equipment)

Medications / Dose	**Medications / Dose**

Specialists	**Phone Number/Fax/E-mail**

Equipment/Transport Information

History

Review of Systems & general/baseline physical/lab data	
HEENT (vision/hearing)	Musculoskeletal
CV	Skin
Respiratory	Neuro
GI	Psych
Hem	Endo
GU	Immune

Coverage Concerns/Recurrent Presenting Problems		
Problem	Diagnostic Studies	Treatment

Support Services

Service	Frequency	Contact Information
Home Care		
PT/OT		
DME		
School/Child Care/EI		
Other		

Hospitalizations/Surgery	Date	Procedures

MEDICAL CARE PLAN

GIFFORD MEDICAL CENTER
RANDOLPH, VERMONT 05060

Name:	**Nick Name:**	**DOB:**
Allergies:	**Complexity:**	
Parent/Guardian:	**Phone #:**	
PCP:	**Insurance:**	
PCP Phone #:	**Parent Emergency #:**	

Special Instructions:

Unique Family Needs/Assets:

Antibiotic Prophylaxis:	***Indications:***	***Medication & Dose:***

PROBLEM LIST	**MED Y / N**	**SPECIALIST INVOLVED**	**OUTCOME**	**HOW OFTEN**	**LAST VISIT**
Health Maintenance					

(*) – See Med Sheet in Chart

MEDICAL CARE PLAN

Patient Name:

PROCEDURES	TESTS	LABS	LAST DONE	VALUE

Other Services:

TYPE OF SERVICE	SERVICE GIVEN BY	FREQUENCY

DEVICES	DATE STARTED

****Unique Immunization Needs:***

Influenza									
Pneumococcal									
RSV									
Other									

(**) For full record see chart.

List of Health Care and Other Service Providers

Child's Name: _____DOB: _____
Dx: 1_____Dx: 2_____Dx:3 _____

Health Care:	Name/Location	Phone #	Fax #	Referral Date
Specialists:				
Special Clinics: (coordinators)				
Other:				

School Services:	Name/Location	Phone #	Fax #	Effective Dates
Early Intervention:				
School attending:				
School Principal(s):				
Classroom teachers:				
School nurse(s):				
Spec. ed. Coordinator:				
Other personnel:				

Community services:	Name/Location	Phone #	Fax #
Family Support coordinator:			
Visiting nurse:			
Mental Health Provider:			
HMO/Insurance contact:			
DCYF case worker:			
Other service providers:			
Informal supports: minister, friend, etc.			

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE

Care Planning

Parent's Names _____ / _____
Child's Name _____ Diagnosis (s) _____
Phones (H) _____ / _____ (W) _____ / _____
Best Time / Place To Call _____ FAX # if available _____

CCM Monitoring: Questioning & Inverventions in the following areas:

Date:				
Family's #1 Issue				
Health Provider's #1 Issue				
Chronic Condition Update (meds, acute episodes, etc.)				
Child's Life/Recent Accomplishments:				
Family Life				
Comm/Family Support Issues				
Financial Issues (insurance, SSI, etc.)				
School Needs				
Specialist Contacts				
Patient Education/Self Care				
Other				

PARENT NOTEBOOK GIVEN (DATE) _____ OFFICE CONTACT PERSON_____

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE
NEXT STEPS NEEDED

Child's Name _____ Phone Number _____
Diagnosis (s) _____

Date	Task	Who	Notes	Date Done

Next appointment needed/Next CCM monitoring visit:

Date Care Plan Last Revised: / / / / / / / / /

CHRONIC CONDIDTION MANAGEMENT (CCM) IN PRIMARY CARE
CARE PLANNING

NOTES:

Hitchcock Clinic—Concord
Pediatric Care Plan Part I

Child's Name_____ Nickname_____ DOB_____

Parent (Caregiver)_____ (Relationship)_____

Address_____

Phone #(home)_____ (Blocked? Y__N__) Best time to reach_____ E-mail_____

Mom Alternate Phone_____ Dad Alternate Phone_____

Emergency Contact_____ Phone _____ Relationship_____

Emergency Contact_____ Phone_____ Relationship_____

Health Insurance/Plan_____ Identification #_____

Diagnose(s): ↓ **➔ Emergency Plan ❒ Yes ❒ No** **Complexity Level**_____

Primary_____	ICD9_____	Primary_____	ICD9_____
Secondary_____	ICD9_____	Secondary_____	ICD9_____
Secondary_____	ICD9_____	Secondary_____	ICD9_____

Allergies/reaction:_____

Medications/dose:_____

PCP_____ **Phone**_____ **Fax**_____ **E-Mail**_____

#1 Specialist/Specialty Clinic/Hospital Phone	Other (fax, e-mail, etc.):
#2	Other (fax, e-mail, etc.):
#3	Other (fax, e-mail, etc.):
#4	Other (fax, e-mail, etc.):

Nursing Service/Respite_____ **Phone** _____

Child's Name: Nickname: Date:

Common Presenting Problems/Findings with Specific Suggested Managements

( ) See specialist letter(s) attached

Problem #1 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #2 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #3 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Comments on child, family, or other specific medical issues:

X

Physician/Provider Signature **Print Name above**

X

Family/guardian *signature* giving consent for release of this information to the emergency room **Print Name above**

Care Plan Part II: Child Description

Name_____ **Nickname**_____ **DOB**_____

Child's Assets & Strengths_____

Vital Sign (baselines)

Ht_____ Wt_____ Temp_____ Other_____

Challenges (check all that apply, please explain on lines below)

❒ Behavioral	❒ Learning	❒ Stamina/Fatigue
❒ Communication	❒ Orthopedic/Musculoskeletal	❒ Respiratory
❒ Feed & Swallowing	❒ Physical Anomalies	❒
Other_____		
❒ Hearing/Vision	❒ Sensory	❒
Other_____		

Procedures/foods/activities to be avoided:

Prior surgeries/procedures:

_____ Date	_____ Date
_____ Date	_____ Date
_____ Date	_____ Date

Most recent labs/diagnostic studies:

Labs	EEG
	EKG
	X-rays
Drug levels	C-Spine
	Other
	Other
MRI/CT	

Care Plan Part II: Child Description

Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

- ❒ Gastrostomy
- ❒ Tracheostomy
- ❒ Suction
- ❒ Nebulizer
- ❒ Adaptive Seating
- ❒ Communication Device
- ❒ Monitors: (✓) __Apnea __O2 __Cardiac__Glucose
- ❒ Wheelchair
- ❒ Orthotics
- ❒ Crutches
- ❒ Walker
- ❒ Other_____

_____

_____

_____

_____

School System/Child Care: **Contact Person/Role:** **Phone:**

_____

_____

_____

_____

Family Information:

Caregivers_____

Siblings_____

Other important facts _____

_____

_____

Special Circumstances/Comment/What you would like us to know

_____

_____

_____

_____

_____ _____

Parent /Caregiver Signature & Date **Primary Care Provider Signature & Date**

CHILD HISTORY FACT SHEET

PATIENT NAME: _____
MR#: _____ DOB: _____
Religion: _____ Nationality: _____
Marital status of parent(s): married separated divorced remarried widowed single
Child resides with: parent(s) mother father guardian foster parent other _____
_____

DNR STATUS: _____
(DNR order should be clearly placed in chart)

People whom the child presently resides with:
Name: Age: Relationship:
_____
_____
_____
_____
_____

TRANSPORTATION: _____
Handicap sticker: _____
Transport Company: _____
Phone: _____ Fax: _____
Special considerations: _____

HOUSING: _____
_____
_____
_____

INSURANCE
•Primary Ins: _____
ID#: _____
Subscriber: _____
Phone #: _____
Case Mgr: _____
•Secondary Ins: _____
ID#: _____
Subscriber: _____
Phone #: _____
Case Mgr: _____
•Medicaid: (type) _____
ID#: _____
Phone #: _____
Case Mgr: _____
•BCMH: _____
ID#: _____
Phone #: _____
Case Mgr: _____
•SSI: _____
_____
•Other: _____
_____
_____

SPECIAL INFO ABOUT ME: _____
_____
_____

CAREGIVERS:
Caregiver _____relationship to child _____
DOB: ___/___/___ SS# _____
Address: _____
_____
Phone(H): _____ Phone(W): _____
Education: _____ Literacy: _____
Disabilities: _____
Employment: _____Hours: _____
_____
_____

Caregiver _____relationship to child _____
DOB: ___/___/___ SS# _____
Address: _____
_____
Phone(H): _____ Phone(W): _____
Education: _____ Literacy: _____
Disabilities: _____
Employment: _____Hours: _____
_____
_____

Other Caregivers/Contact persons: _____
_____
_____
_____

PROGRAMS
•Early Intervention Services: _____
_____
Case Mgr: _____ Phone: _____
•MRDD Services: _____
_____
Case Mgr: _____ Phone: _____
•Family Resources: _____
•WIC: Office: _____
Phone: _____ Fax: _____
•Hospice Provider: _____
Contact: _____
Phone: _____ Fax: _____
•School: _____
Phone: _____ Fax: _____
_____
•Other: _____
_____
_____
_____
_____
_____
_____
_____

HOME CARE AGENCY

Name: _____
Phone: _____ Fax: _____
Hours/Shifts: _____
Services Provided: _____
Supervisor: _____
Name: _____
Phone: _____ Fax: _____
Hours/Shifts: _____
Services Provided: _____
Supervisor: _____

DME

Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____
Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____
Name: _____ Contact: _____
Phone: _____ Fax: _____
Supplies provided: _____
_____

THERAPIES

OT Provider: _____ Contact: _____
Phone: _____Fax: _____
Frequency: _____
PT Provider: _____Contact: _____
Phone: _____Fax: _____
Frequency: _____
ST Provider: _____Contact: _____
Phone: _____Fax: _____
Frequency: _____
Therapies at school: _____
_____

SPECIALISTS:

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____

•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
•MD: _____ Division: _____
Phone: _____ Fax: _____
Contact: _____
_____
_____
_____
_____
_____

SPECIAL LETTERS TO FAMILIES:

•Electric Co:

_____

•Water/Sewage:

_____

•Fire Department:

_____

•Telephone Co:

_____

SUPPORT AND RESOURCES FAMILY RELIES ON:

_____
_____
_____
_____
_____
_____
_____

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Section Two: Specialized Emergency Information

(Medical Information / Emergency Care Plan)

CMHI

NICHQ
National Initiative for Children's Healthcare Quality

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name:	Birth date:	Nickname:
Home Address:	Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:	
Signature/Consent*:		
Primary Language:	Phone Number(s):	

Physicians:

Primary care physician:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Current Specialty physician: Specialty:	Emergency Phone:
	Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	

Diagnoses/Past Procedures/Physical Exam:

1 .

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations

Dates						**Dates**					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Hitchcock Clinic—Concord
Pediatric Care Plan Part I

Child's Name_____Nickname_____DOB_____

Parent (Caregiver)_____(Relationship)_____

_____

Address_____

Phone #(home)_____(Blocked? Y__N__) Best time to reach_____E-mail_____

Mom Alternate Phone_____Dad Alternate Phone_____

_____

Emergency Contact_____Phone _____Relationship_____

Emergency Contact_____Phone_____Relationship_____

Health Insurance/Plan_____Identification #_____

_____

Diagnose(s): ↓ **→ Emergency Plan ❒ Yes ❒ No Complexity Level**_____

Primary_____ICD9_____ Primary_____ICD9_____

Secondary_____ICD9_____ Secondary_____ICD9_____

Secondary_____ICD9_____ Secondary_____ICD9_____

Allergies/reaction:_____ _____

_____ _____

Medications/dose:_____ _____

_____ _____

_____ _____

PCP_____**Phone**_____**Fax**_____**E-Mail**_____

#1 Specialist/Specialty Clinic/Hospital Phone	Other (fax, e-mail, etc.):
#2	Other (fax, e-mail, etc.):
#3	Other (fax, e-mail, etc.):
#4	Other (fax, e-mail, etc.):

Nursing Service/Respite_____**Phone** _____

Child's Name: Nickname: Date:

Common Presenting Problems/Findings with Specific Suggested Managements

( ) See specialist letter(s) attached

Problem #1 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #2 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Problem #3 **Presenting Signs & Symptoms**

Suggested Diagnostic Studies: Treatment Considerations:

Comments on child, family, or other specific medical issues:

X

Physician/Provider Signature **Print Name above**

X

Family/guardian *signature* giving consent for release of this information to the emergency room **Print Name above**

Care Plan Part II: Child Description

Name_____ **Nickname**_____ **DOB**_____

Child's Assets & Strengths_____

Vital Sign (baselines)

Ht_____ Wt_____ Temp_____ Other_____

Challenges (check all that apply, please explain on lines below)

❒ Behavioral	❒ Learning	❒ Stamina/Fatigue
❒ Communication	❒ Orthopedic/Musculoskeletal	❒ Respiratory
❒ Feed & Swallowing	❒ Physical Anomalies	❒
Other_____		
❒ Hearing/Vision	❒ Sensory	❒
Other_____		

Procedures/foods/activities to be avoided:

Prior surgeries/procedures:

_____ Date	_____ Date
_____ Date	_____ Date
_____ Date	_____ Date

Most recent labs/diagnostic studies:

Labs	EEG
	EKG
	X-rays
Drug levels	C-Spine
	Other
	Other
MRI/CT	

Care Plan Part II: Child Description

Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

- ❒ Gastrostomy
- ❒ Tracheostomy
- ❒ Suction
- ❒ Nebulizer
- ❒ Adaptive Seating
- ❒ Communication Device
- ❒ Monitors: (✓) __Apnea __O2 __Cardiac__Glucose
- ❒ Wheelchair
- ❒ Orthotics
- ❒ Crutches
- ❒ Walker
- ❒ Other_____

_____

_____

_____

_____

School System/Child Care: **Contact Person/Role:** **Phone:**

_____

_____

_____

_____

Family Information:

Caregivers_____

Siblings_____

Other important facts _____

_____

_____

Special Circumstances/Comment/What you would like us to know

_____

_____

_____

_____

_____ _____

Parent /Caregiver Signature & Date **Primary Care Provider Signature & Date**

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Section Three: Working (Action) Care Plans

CMHI

NICHQ
National Initiative for Children's Healthcare Quality

List of Health Care and Other Service Providers

Child's Name:_____DOB:_____

Dx:1_____Dx2_____Dx3_____

Health Care:	Name/Location	Phone #	Fax #	Referral Date
Specialists:				
Special clinics: (coordinators)				
Other:				

School Services:	Name/Location	Phone #	Fax #	Effective Dates
Early intervention:				
School attending:				
School principal(s):				
Classroom teacher(s):				
School nurse(s):				
Spec. ed. coordinator:				
Other personnel:				

Community services:	Name/Location	Phone #	Fax #
Family support coordinator:			
Visiting nurse:			
Mental health provider:			
HMO/Insurance contact:			
DCYF case worker:			
Other service providers:			
Informal supports: minister, friend, etc.)			

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE

Care Planning

Parent's Names_____ / _____

Child's Name _____ Diagnosis(s) _____

Phones(H) _____ /_____ (W)_____ / _____

Best Time / Place To Call _____ FAX # if available _____

CCM Monitoring: Questioning & Interventions in the following areas:

Date:				
Family's #1 Issue				
Health Provider's #1 Issue				
Chronic Condition Update (meds, acute episodes, etc.)				
Child's Life/ Recent Accomplishments:				
Family Life				
Comm/Family Support Issues				
Financial Issues (insurance, SSI, etc.)				
School Needs				
Specialist Contacts				
Patient Education/ Self Care				
Other				

PARENT NOTEBOOK GIVEN (DATE)_____ OFFICE CONTACT PERSON_____

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE
NEXT STEPS NEEDED

Child's Name _____ Phone Number_____
Diagnosis(s)_____

Date	Task	Who	Notes	Date Done

Next appointment needed/Next CCM monitoring visit:

Date Care Plan Last Revised: / / / / / / / /

CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE

CARE PLANNING

NOTES:

Medical Home Learning Collaborative
Action Care Plan

Child's name: DOB: Parents/Guardians:
Primary diagnosis: Secondary Diagnosis: Secondary diagnosis(s)

Original Date of plan: Updated Plan: / / / / /

Main Concerns	**Related Current Clinical Information (sx, labs, etc)**	**Current Plans/Interventions**	**Person(s) Responsible**	**Due Date & Date Completed**

Parent/Caregiver Signature:

Clinician Signature: Name Care Coordinator:

NASHAWAY PEDIATRICS – UMassMemorial Health Care
P.O. Box 639
Sterling, MA 01564
Phone (978) 422-6900 Fax (978) 422-7561

Richard C. Antonelli, MD, FAAP
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Deborah Francis, MD, FAAP
Elizabeth Madden, PNP

EVERY CHILD DESERVES A MEDICAL HOME.

AMERICAN ACADEMY OF PEDIATRICS

Medical Home Family-Centered Health Care Plan

Prepared for: _____ Prepared by: _____ Nashaway Contact Person: _____ **Date Prepared:**_____

Problem	**Activity**	**Who will do**	**When**	**Expected Outcome**	**Follow-Up**

Resources

UMMHC: (508) 856-0011
Early Intervention: (978) 537-0956 (Leominster)
(508) 856-4202 (Worcester)
DPH Case Management: (508) 792-7880
Memorial Rehab: (508) 792-8700
Family TIES: (800) 905-TIES

CHADD (Leominster): (978) 840-6823
SSI Eligibility: (800) 772-1213
Federation for Children with Special Needs: (800) 331-0688
MSPCC Parents as Teachers Program: (800) 442-3035
Nashaway Pediatrics: www.nashawaypediatrics.yourmd.com
NICHCY (Information Center): (800) 895-0285