Health Care Transition Summary

Name _____ DOB _____ SS# _____

Address _____
Street City State Zip

Phone _____
Home Work Cell

Emergency Contact: _____ Relationship: _____ Phone: _____

Guardian/Health Surrogate:_____ Relationship: _____ Phone: _____

Unique Communication/Cultural Needs: _____

Strengths/Assets: _____

Assistive Technology: _____

Primary Insurance: _____
Policy # Case Manager Phone #

Secondary Insurance:_____
Policy # Case Manager Phone #

Allergies: _(meds & food)_____

Recent Lab, X-ray Findings: _____

Height: _____Weight: _____ Dietary/Nutritional Needs: _____

Primary Care Provider:_____ Phone:_____

Address: _____
Street City State Zip

Diagnosis	Managing Provider/ Specialist	Address	Phone
1.			
2.			
3.			
4.			
5.			

Current Medications	Current Medications
1.	5.
2.	6.
3.	7.
4.	8.

Current Therapies	Frequency	Provider	Contact Information
1.			
2.			
3.			

Medical Equipment	Medical Supplies	Provider	Contact Information
1.			
2.			
3.			
4.			

Orthotics & Prosthetics	Provider	Contact Information
1.		
2.		

Past Hospitalizations (including surgeries)			
Date	Hospital Name	Reason	Physician

Functional Capabilities	Brief Summary
Upper Extremities	
Lower Extremities	
Speech/Language	
Cognitive/ Problem Solving	

Future Plans (including agencies involved & referral made)
Health Care
Health Insurance
School & Work
Independent Living (housing, transportation, attendant care)

Services Currently Receiving	Provider Contact Information
1.	
2.	
3.	
4.	

Signature Youth: _____ Date Completed: _____