Pediatric Care Plan and Patient Summary

Practice Logo

Practice/ Site Name:
Office Address:
Office Phone:
Office Fax:
Office Hours:

Weekend appointments available for urgent needs, call the office number above.

24 hours per day/365 days per year:

On-Call Staff is Available: Call the office number above.

Call 911 for medical emergencies!

Child's Name:	**Date:**
Date of Birth:	
Primary Care Pediatrician:	
Pediatric Care Coordinator:	
Other Pediatric Care Team Members:	

Specialist Physician(s)	**Role:**	**Phone:**	**Follow-up Due:**

Child's Care Summary:	
Ongoing Medical Diagnoses:	
Allergies:	
Medications:	
Equipment/Appliances/ Assistive Technology:	
Emergency Information to Know:	

Your next follow-up appointment Date is: _____ with provider: _____

Pediatric Care Plan and Patient Summary

☺ Keep up the Good Work!

GOALS:

TO DO:

Child/ Parent/ Family:	
Pediatric Care Coordinator or Team:	
Pediatrician:	
Other:	

Community Resources/ Referrals:

My Care Plan

Child's Name: _____ **Date:** _____

Your Pediatric Care Team: Provider: _____ **ADHD Coordinator:**_____

Your next follow-up appointment for ADHD is: _____

School Information:

School Name:_____ Grade Level:_____

Key Teacher Contact Name:_____

Email Address:_____ Phone:_____ Fax:_____

Other Specialists:

Specialist:	Role:	Phone:	Follow-up Due:

☺ Keep up the Good Work!

You are doing well at home and school by doing the following:

- ☐ Taking your medication regularly
- ☐ Completing assignments on time and turning them in
- ☐ Missing few days of school or other activities
- ☐ Scheduling regular maintenance appointments with your Pediatrician Care Team
- ☐ Other:

GOALS: What improvements would you most like to see?

- ☐ Remember to take medication
- ☐ Remember to complete planner
- ☐ Complete assignments on time
- ☐ Turn in assignments on time
- ☐ Increase time listening to others
- ☐ Eating healthy meals
- ☐ Miss fewer days of school
- ☐ Other _____

Medication Information:

Medication:			
1.	**Time _____ am/pm** **Dose 1 _____ mg**	**Time _____ am/pm** **Dose 2 _____ mg**	**Time _____ am/pm** **Dose 3 _____ mg**
2.	**Time _____ am/pm** **Dose 1 _____ mg**	**Time _____ am/pm** **Dose 1 _____ mg**	**Time _____ am/pm** **Dose 1 _____ mg**

Common Side Effects: decreased appetite, sleep problems, transient stomachache, transient headache, behavioral rebound
Call your doctor immediately in any infrequent side effects occur: weight loss, increased heart rate and/or blood pressure, dizziness, growth suppression, hallucinations/mania, exacerbation of tics and Tourette syndrome (rare)

Further Evaluation/Treatment Needed:

- ☐ School evaluation/testing
- ☐ Psychological evaluation/testing referral: _____
- ☐ Teacher consultation
- ☐ Follow-up Parent Vanderbilt given
- ☐ Follow-up Teacher Vanderbilt given to parent ___ or faxed to school ___
- ☐ Behavioral Modification/Counseling referral: _____
- ☐ Other:

Additional Resources and Strategies:

- ☐ Community Resources/Referrals: _____
- ☐ CHADD: CHADD.org or Phone number: 800/233-4050
- ☐ Other: