



SECTION 1

MEDICAL HISTORY & CARE



This section contains your child's medical history organized by specialty.

Keeping records together by provider makes it easier to prepare for appointments, share information with new care teams, and quickly locate important documents when they're needed most.



*Within each specialty, file the newest records at the front
so the most current information is always easy to find.*



Your child. Your records. Your voice. Always with you.



NEUROMUSCULAR CLINIC



PROVIDER INFORMATION

Primary Neuromuscular Physician _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Clinic notes
- ☒ Genetic testing reports
- ☒ Neurological exams
- ☒ Pulmonary Function Tests
- ☒ Sleep study results
- ☒ EMG / Nerve Conduction
- ☒ Laboratory tests
- ☒ Medication Changes
- ☒ Care Recommendations
- ☒ Other Neuromuscular Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



NEUROMUSCULAR CLINIC

Specialty Profile

This page provides an enduring overview of your child's neuromuscular care.
Update only when information changes significantly.



CARE TEAM

Primary Neuromuscular Physician _____
Clinic / Hospital _____
Phone _____
Care Coordinator _____
Phone _____
Clinic Website _____



2 DIAGNOSIS INFORMATION

Primary Diagnosis _____
Genetic Variant _____
Date Diagnosed _____
Age at Diagnosis _____ Current Age _____
Ambulatory Status (check one)
☐ Ambulatory ☐ Non-Ambulatory ☐ Power Wheelchair
Gene Therapy Received
☐ Yes ☐ No If yes, date _____
Current Steroid Therapy
☐ Yes ☐ No If yes, which _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Cardiac Surveillance | ☐ Nutrition / Dietetics |
| ☐ Pulmonary Surveillance | ☐ Mental Health Support |
| ☐ Physical Therapy | ☐ Palliative Care |
| ☐ Occupational Therapy | ☐ Other _____ |
| ☐ Speech Therapy | ☐ Other _____ |



DURABLE MEDICAL EQUIPMENT

Equipment currently used:

- | | |
|---|---|
| ☐ Manual Wheelchair | ☐ Lift / Hoyer Lift |
| ☐ Power Wheelchair | ☐ Shower Chair / Commode |
| ☐ Standing Device | ☐ Orthotics / Bracing |
| ☐ Cough Assist | ☐ Communication Device |
| ☐ BiPAP / Ventilator | ☐ Other _____ |



BASELINE FUNCTIONAL STATUS

Current baseline (check all that apply):

- | | |
|---|--|
| ☐ Walks independently | ☐ Independent in daily activities |
| ☐ Requires assistance to walk | ☐ Requires assistance for ADLs |
| ☐ Uses wheelchair | ☐ Speech is understandable |
| ☐ Transfers independently | ☐ Uses communication support |
| ☐ Requires assistance with transfers | ☐ Feeds independently |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's neuromuscular care at a glance, no matter when or where care is provided.



TIP:

Review this page at least once a year or when major changes occur.



NEUROMUSCULAR CLINIC

Visit Summary

Use this page to capture key information from each visit.

Place this summary at the front of the visit records in this section.



Keep your most recent visit summaries at the front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|--|---|
| ☐ Physical Exam | ☐ Genetic Testing |
| ☐ Pulmonary Function Test (PFT) | ☐ EMG / Nerve Conduction |
| ☐ Sleep Study | ☐ Swallow Study |
| ☐ Strength Assessment | ☐ Mobility / Functional Assessment |
| ☐ Labs | ☐ Other _____ |
| ☐ Imaging (MRI / Other) | ☐ Other _____ |

See Test Tracker for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

- ☐ New Medication
☐ Dose Change
☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

- ☐ New Therapy
☐ Change in Frequency
☐ Discontinued

Details: _____



EQUIPMENT / SUPPLY CHANGES

- ☐ New Equipment
☐ Equipment Adjustment
☐ Repairs / Replacement

Details: _____



OTHER CHANGES

- ☐ Care Plan Update
☐ Activity / Restrictions
☐ Other _____

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place the clinic note, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____



CARDIOLOGY



PROVIDER INFORMATION

Primary Cardiologist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Clinic notes
- ☒ Echocardiograms
- ☒ ECGs
- ☒ Holter Monitor Reports
- ☒ Cardiac MRI
- ☒ Medication Changes
- ☒ Care Recommendations
- ☒ Other Cardiology Records







Keep the newest records at the front of this section.



CARDIOLOGY

Specialty Profile

This page provides an enduring overview of your child's cardiology care.
Update only when information changes significantly.



CARE TEAM

Primary Cardiologist _____
Clinic / Hospital _____
Care Coordinator _____
Phone _____
Clinic Website _____



2 DIAGNOSIS INFORMATION

Primary Cardiac Diagnosis _____
Cardiac Findings / Concerns _____
Date Diagnosed _____
Age at Diagnosis _____ Current Age _____
Cardiac Medications (check one)
☐ Yes ☐ No If yes, which _____
Arrhythmia Monitoring (check one)
☐ Yes ☐ No If yes, type _____
Other Cardiac Conditions _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care:

- | | |
|--|--|
| ☐ Cardiac Surveillance | ☐ Mental Health Support |
| ☐ Medication Management | ☐ Palliative Care |
| ☐ Nutrition / Dietetics | ☐ Social Work Support |
| ☐ Physical Therapy | ☐ Home Nursing |
| ☐ Occupational Therapy | ☐ Other _____ |
| ☐ Speech Therapy | ☐ Other _____ |



DURABLE MEDICAL EQUIPMENT

Equipment currently used:

- | | |
|---|---|
| ☐ Blood Pressure Monitor | ☐ Automated External Defibrillator (AED) |
| ☐ Pulse Oximeter | ☐ Medication Organizer |
| ☐ Heart Rate Monitor | ☐ Stethoscope |
| ☐ ECG / Holter Monitor | ☐ Other _____ |
| ☐ Scale | |
| ☐ Other _____ | |



BASELINE FUNCTIONAL STATUS

Current baseline (check all that apply):

- | | |
|---|--|
| ☐ Walks independently | ☐ Independent in daily activities |
| ☐ Requires assistance to walk | ☐ Requires assistance for ADLs |
| ☐ Uses wheelchair | ☐ Speech is understandable |
| ☐ Transfers independently | ☐ Uses communication support |
| ☐ Requires assistance with transfers | ☐ Feeds independently |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives providers a quick understanding of your child's cardiology care at a glance.



TIP:

Review this page at least once a year or when major changes occur.





CARDIOLOGY

Visit Summary

Use this page to capture key information from each visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.

 Visit Date _____

 Provider _____

 Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|--|--|
| ☐ Physical Exam | ☐ Labs (Blood Work) |
| ☐ Echocardiogram | ☐ Medication Review |
| ☐ ECG (Electrocardiogram) | ☐ Stress Test |
| ☐ Holter Monitor | ☐ Other _____ |
| ☐ Cardiac MRI | ☐ Other _____ |

See Test Tracker for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

- ☐ New Medication
- ☐ Dose Change
- ☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

- ☐ New Therapy
- ☐ Change in Frequency
- ☐ Discontinued

Details: _____



EQUIPMENT / SUPPLY CHANGES

- ☐ New Equipment
- ☐ Equipment Adjustment
- ☐ Repairs / Replacement

Details: _____



OTHER CHANGES

- ☐ Care Plan Update
- ☐ Activity / Restrictions
- ☐ Other _____

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____

☐ _____

☐ _____

☐ _____

Questions I Still Have

☐ _____

☐ _____

☐ _____

☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
- ☐ Patient
- ☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place the clinic note, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





PULMONOLOGY



PROVIDER INFORMATION

Primary Pulmonologist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Clinic notes
- ☒ Pulmonary Function Tests
- ☒ Sleep Studies
- ☒ Cough Assist Evaluations
- ☒ Overnight Oximetry
- ☒ Ventilation / BiPAP Reports
- ☒ Medication Changes
- ☒ Care Recommendations
- ☒ Other Pulmonology Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



PULMONOLOGY

Specialty Profile

This page provides an enduring overview of your child's pulmonology care.
Update only when information changes significantly.



CARE TEAM

Primary Pulmonologist _____
Clinic / Hospital _____
Phone _____
Care Coordinator _____
Phone _____
Respiratory Therapist _____
Clinic Website _____



DIAGNOSIS INFORMATION

Primary Pulmonary Diagnosis _____
Respiratory Findings / Concerns _____
Date Diagnosed _____ Age at Diagnosis _____
Current Age _____
Ventilatory Support
☐ None ☐ Nighttime ☐ Daytime ☐ 24 Hour
Cough Assist Used ☐ Yes ☐ No
Supplemental Oxygen ☐ Yes ☐ No If yes, L/min _____
Airway Clearance Needs _____
Other Respiratory Support / Equipment _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Pulmonary Surveillance | ☐ Physical Therapy |
| ☐ Sleep Medicine | ☐ Nutrition / Dietetics |
| ☐ Respiratory Therapy | ☐ Mental Health Support |
| ☐ Airway Clearance Program | ☐ Palliative Care |
| ☐ Occupational Therapy | ☐ Other _____ |



DURABLE MEDICAL EQUIPMENT

Equipment currently used:

- | | |
|---|--|
| ☐ Cough Assist | ☐ Oxygen Concentrator / Tanks |
| ☐ BiPAP / Ventilator | ☐ Chest Vest |
| ☐ Suction Machine | ☐ Peak Flow Meter |
| ☐ Pulse Oximeter | ☐ Other _____ |
| ☐ Nebulizer | ☐ Other _____ |



BASELINE FUNCTIONAL STATUS

Current baseline (check all that apply):

- | | |
|---|--|
| ☐ Walks independently | ☐ Independent in daily activities |
| ☐ Requires assistance to walk | ☐ Requires assistance for ADLs |
| ☐ Uses wheelchair | ☐ Speech is understandable |
| ☐ Transfers independently | ☐ Uses communication support |
| ☐ Requires assistance with transfers | ☐ Feeds independently |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives providers a quick understanding of your child's pulmonology care at a glance, no matter when or where care is provided.



TIP:

Review this page at least once a year or when major changes occur.





PULMONOLOGY

Visit Summary

Use this page to capture key information from each visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|--|---|
| ☐ Physical Exam | ☐ Imaging (X-ray / CT) |
| ☐ Pulmonary Function Test (PFT) | ☐ Ventilation / BiPAP Review |
| ☐ Sleep Study | ☐ Swallow Study |
| ☐ Cough Assist Evaluation | ☐ 6MWT (6-Minute Walk Test) |
| ☐ Overnight Oximetry | ☐ Other _____ |
| ☐ Labs | ☐ Other _____ |

See Test Tracker for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

- ☐ New Medication
☐ Dose Change
☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

- ☐ New Therapy
☐ Change in Frequency
☐ Discontinued

Details: _____



EQUIPMENT / SUPPLY CHANGES

- ☐ New Equipment
☐ Equipment Adjustment
☐ Repairs / Replacement

Details: _____



OTHER CHANGES

- ☐ Care Plan Update
☐ Activity / Restrictions
☐ Other _____

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place the clinic note, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





PRIMARY CARE

PRIMARY CARE



This section includes your child's primary care records and general health information.

Keeping records together by provider makes it easier to prepare for appointments, share information with new care teams, and quickly locate important documents when they're needed most.

Within each specialty, file the newest records at the front so the most current information is always easy to find.



Your child. Your records. Your voice. Always with you.



PRIMARY CARE

Specialty Profile

This page provides an enduring overview of your child's primary care.
Update only when information changes significantly.



CARE TEAM

Primary Care Provider _____

Clinic / Practice _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



HEALTH INFORMATION

Primary Diagnosis _____

Other Diagnoses _____

Date of Birth _____

Primary Pharmacy _____

Immunizations Current ☐ Yes ☐ No

Preferred Hospital _____



ONGOING CARE & SERVICES

Services currently part of ongoing care:

- | | |
|--|--|
| ☐ Routine Wellness Visits | ☐ Nutrition / Dietetics |
| ☐ Vaccinations | ☐ Mental Health Support |
| ☐ Care Coordination | ☐ Social Work / Case Management |
| ☐ School / Work Forms | ☐ Other |



MEDICAL EQUIPMENT / SUPPORTS

Equipment currently used:

- | | |
|---|---|
| ☐ Power Wheelchair | ☐ Lift / Hoyer Lift |
| ☐ Manual Wheelchair | ☐ Shower Chair / Commode |
| ☐ Cough Assist | ☐ Communication Device |
| ☐ BiPAP / Ventilator | ☐ Other |



BASELINE HEALTH STATUS

Current baseline (check all that apply):

- | | |
|---|---|
| ☐ Stable overall health | ☐ Has respiratory support |
| ☐ Needs help with daily activities | ☐ Has cardiac monitoring |
| ☐ Uses wheelchair | ☐ Has swallowing concerns |
| ☐ Receives home supports | ☐ Has chronic pain / fatigue |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



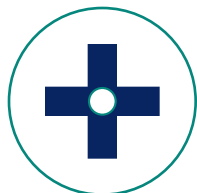
WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's primary care needs at a glance, no matter when or where care is provided.



TIP:

Review this page at least once a year or when major changes occur.



PRIMARY CARE

Visit Summary

Keep a summary of each visit to track care, recommendations, and next steps.
File visit summaries in chronological order with the newest at the front.



VISIT INFORMATION

Visit Date _____

Provider _____

Clinic / Location _____

Visit Type

☐ Routine Follow-Up ☐ New Patient ☐ Annual Wellness

☐ Other _____

Next Visit Date _____



VISIT SUMMARY

Reason for Visit

Summary of Visit / Findings

Recommendations / Plan

Orders / Referrals / Tests

Medications / Treatment Changes



Keep the newest records at the front.



Your child. Your records. Your voice. Always with you.

LAST REVISION DATE

___ / ___ / ___



PHYSICAL THERAPY



PROVIDER INFORMATION

Primary Physical Therapist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Physical therapy evaluations
- ☒ Range-of-motion assessments
- ☒ Strength / functional assessments
- ☒ Mobility / gait assessments
- ☒ Stretching / exercise plans
- ☒ Transfer training notes
- ☒ Equipment evaluations
- ☒ Home / school recommendations
- ☒ Progress notes
- ☒ Care recommendations
- ☒ Other Physical Therapy Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



PHYSICAL THERAPY

Specialty Profile

This page provides an enduring overview of your child's physical therapy care.
Update only when information changes significantly.



CARE TEAM

Primary Physical Therapist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



THERAPY INFORMATION

Primary PT Concerns _____

Referring Diagnosis _____

Date Therapy Began _____

Current Therapy Frequency _____

School / Work Setting _____

Home Exercise Program
☐ Yes ☐ No Last updated _____

Primary Functional Goals _____



DURABLE MEDICAL EQUIPMENT

Equipment currently used:

☐ Manual Wheelchair	☐ Shower Chair / Commode
☐ Power Wheelchair	☐ Orthotics / Bracing
☐ Standing Device	☐ Positioning Supports
☐ Walker / Gait Trainer	☐ Other _____
☐ Lift / Transfer Aid	☐ Other _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Physical Therapy | ☐ Neuromuscular Clinic |
| ☐ Occupational Therapy | ☐ School-Based Services |
| ☐ Speech Therapy | ☐ Home Health / Nursing |
| ☐ Orthopedics | ☐ Palliative Care |
| ☐ PM&R | ☐ Other _____ |



BASELINE FUNCTIONAL STATUS

Current baseline (check all that apply):

- | | |
|---|--|
| ☐ Walks independently | ☐ Independent in daily activities |
| ☐ Requires assistance to walk | ☐ Requires assistance for ADLs |
| ☐ Uses wheelchair | ☐ Uses communication support |
| ☐ Transfers independently | ☐ Pain limits function |
| ☐ Requires help with transfers | ☐ Feeds independently |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's physical therapy needs, equipment, functional goals, and precautions.



TIP:

Review this page at least once a year or when major changes occur.





PHYSICAL THERAPY

Visit Summary

Use this page to capture key information from each physical therapy visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.

 **Visit Date** _____

 **Provider** _____

 **Clinic / Location** _____

Reason for Visit _____

TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|---|--|
| ☐ Functional assessment | ☐ Balance assessment |
| ☐ Range of motion | ☐ Equipment evaluation |
| ☐ Strength assessment | ☐ Orthotics / bracing check |
| ☐ Mobility / gait assessment | ☐ Home / school access |
| ☐ Transfer assessment | ☐ Other |

See therapy records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES

THERAPY / TREATMENT CHANGES

- ☐ New therapy goal
- ☐ Change in frequency
- ☐ Home program updated

Details: _____

EQUIPMENT / SUPPLY CHANGES

- ☐ New equipment
- ☐ Adjustment / repair
- ☐ New orthotic / brace

Details: _____

MOBILITY / ACCESS CHANGES

- ☐ Mobility status change
- ☐ Transfer support
- ☐ Accessibility update

Details: _____

OTHER CHANGES

- ☐ Care plan update
- ☐ Activity / restrictions
- ☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____

☐ _____

☐ _____

☐ _____

Questions I Still Have

☐ _____

☐ _____

☐ _____

☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
- ☐ Patient
- ☐ Other

Date Completed _____

TIP:

Complete this summary during or right after the visit while information is fresh.
Then place therapy notes, evaluations, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





OCCUPATIONAL THERAPY



PROVIDER INFORMATION

Primary Occupational Therapist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ OT evaluations
- ☒ Functional assessments
- ☒ Fine-motor testing
- ☒ Range-of-motion records
- ☒ Splinting / orthotics notes
- ☒ ADL assessments
- ☒ Equipment evaluations
- ☒ Home / school accessibility
- ☒ Therapy plans and goals
- ☒ Progress notes
- ☒ Care recommendations
- ☒ Other Occupational Therapy Records
- ☐ _____
- ☐ _____



Keep the newest records at the front of this section.



OCCUPATIONAL THERAPY

Specialty Profile

This page provides an enduring overview of your child's occupational therapy care.
Update only when information changes significantly.



CARE TEAM

Primary Occupational Therapist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



2

DIAGNOSIS INFORMATION

Primary OT Concerns _____

Referring Diagnosis _____

Date Therapy Began _____

Current Therapy Frequency _____

School / Work Setting _____

Current Splints / Orthotics
☐ Yes ☐ No If yes, which _____

Primary Functional Goals _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care: _____

Services currently part of ongoing care:

- | | |
|--|--|
| ☐ Occupational Therapy | ☐ Social Work / Case Management |
| ☐ Physical Therapy | ☐ Mental Health Support |
| ☐ Speech Therapy | ☐ Palliative Care |
| ☐ School-Based Services | ☐ Other |
| ☐ Assistive Technology | ☐ Other |



DURABLE MEDICAL EQUIPMENT

Equipment currently used: _____

Equipment currently used:

- | | |
|---|---|
| ☐ Manual Wheelchair | ☐ Adaptive Utensils |
| ☐ Power Wheelchair | ☐ Positioning Supports |
| ☐ Transfer Equipment | ☐ Communication Device |
| ☐ Shower Chair / Commode | ☐ Other |
| ☐ Splints / Orthotics | ☐ Other |



BASELINE FUNCTIONAL STATUS

Current baseline (check all that apply):

- | | |
|--|--|
| ☐ Walks independently | ☐ Independent in daily activities |
| Current baseline (check all that apply): | |
| ☐ Feeds independently | ☐ Needs help toileting |
| ☐ Needs help dressing | ☐ Needs transfer assistance |
| ☐ Needs help grooming | ☐ Uses upper-extremity support |
| ☐ Needs help bathing | ☐ Uses adaptive equipment |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's occupational therapy needs, goals, supports, and equipment.



TIP:

Review this page at least once a year or when major changes occur.



OCCUPATIONAL THERAPY

Visit Summary

Use this page to capture key information from each occupational therapy visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|---|--|
| ☐ Functional assessment | ☐ Seating / positioning |
| ☐ Range of motion | ☐ Splint / orthotic check |
| ☐ Upper-extremity strength | ☐ Equipment assessment |
| ☐ ADL evaluation | ☐ Home / school access |
| ☐ Fine-motor assessment | ☐ Other |

See therapy records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

THERAPY / TREATMENT CHANGES

- ☐ New therapy goal
☐ Change in frequency
☐ Home program updated

Details: _____



THERAPY / TREATMENT CHANGES

EQUIPMENT / SUPPLY CHANGES

- ☐ New equipment
☐ Adjustment / repair
☐ New splint / orthotic

Details: _____



EQUIPMENT / SUPPLY CHANGES

HOME / SCHOOL MODIFICATIONS

- ☐ Accessibility change
☐ Positioning support
☐ Adaptive strategy

Details: _____



OTHER CHANGES

OTHER CHANGES

- ☐ Care plan update
☐ Activity / restrictions
☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place therapy notes, evaluations, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____



GASTROENTEROLOGY



PROVIDER INFORMATION

Primary Gastroenterologist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:



Clinic notes



Endoscopy / colonoscopy reports



Liver function / GI lab results



Swallow study or feeding evaluations



Nutrition / dietitian notes



Imaging reports



Medication Changes



Care Recommendations



Hospital discharge summaries



Other Gastroenterology Records







Keep the newest records at the front of this section.



GASTROENTEROLOGY

Specialty Profile

This page provides an enduring overview of your child's gastroenterology care.
Update only when information changes significantly.

CARE TEAM

Primary Gastroenterologist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____

DIAGNOSIS INFORMATION

Primary Diagnosis _____

Secondary Diagnosis _____

Date Diagnosed _____

Current Concerns _____

Feeding Tube ☐ Yes ☐ No If yes, type _____

Current GI Medications _____

LONG-TERM CARE SERVICES

- | | |
|--|---|
| ☐ GI / Motility Follow-Up | ☐ Nutrition / Dietetics |
| ☐ Feeding Therapy | ☐ Speech / Swallow Therapy |
| ☐ Mental Health Support | ☐ Palliative Care |
| ☐ Other | ☐ Other |

MEDICAL EQUIPMENT / SUPPORTS

- | | |
|--|--|
| ☐ Feeding Pump | ☐ Feeding Tube Supplies |
| ☐ Suction | ☐ Specialized Formula |
| ☐ Adaptive Seating During Meals | ☐ Other |

BASELINE FUNCTIONAL STATUS

- | | |
|---|---|
| ☐ Eats by mouth independently | ☐ Needs help with meals |
| ☐ Uses modified diet / thickened liquids | ☐ Has swallowing concerns |
| ☐ Uses feeding tube for some nutrition | ☐ Uses feeding tube for full nutrition |
| ☐ Has chronic constipation | ☐ Has reflux / GERD |

ALLERGIES / PRECAUTIONS

LONG-TERM CARE GOALS

WHY THIS MATTERS

This profile gives every provider a quick understanding of your child's gastroenterology care at a glance, no matter when or where care is provided.

TIP: Review yearly or whenever major changes occur.

LAST REVISION DATE



GASTROENTEROLOGY

Visit Summary

Use this page to capture key information from each visit.
Place this summary at the front of the visit records in this section.



Keep your most recent visit summaries at the front of this section.



Visit Date _____

Reason for Visit _____



Provider _____



Clinic / Location _____



TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|---|---|
| ☐ Physical Exam | ☐ Swallow / Feeding Assessment |
| ☐ Labs | ☐ Nutrition Assessment |
| ☐ Imaging (X-ray / Ultrasound) | ☐ Stool Testing |
| ☐ Endoscopy | ☐ Other _____ |
| ☐ Colonoscopy | ☐ Other _____ |

See Test Tracker for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

- ☐ New Medication
☐ Dose Change
☐ Discontinued

Details: _____



DIET / NUTRITION CHANGES

- ☐ New Diet Plan
☐ Formula Change
☐ Feeding Schedule Change
☐ Discontinued

Details: _____



EQUIPMENT / SUPPLY CHANGES

- ☐ New Equipment
☐ Supply Adjustment
☐ Repairs / Replacement

Details: _____



OTHER CHANGES

- ☐ Care Plan Update
☐ Activity / Restrictions
☐ Other _____

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____

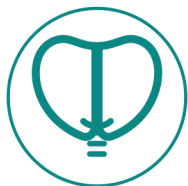


TIP: Complete this summary during or right after the visit while information is fresh.
Then place the clinic note, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





ENDOCRINOLOGY

ENDOCRINOLOGY CLINIC



This section includes your child's endocrine care records, including growth, puberty, bone health, steroid-related monitoring, adrenal health, thyroid function, and blood sugar screening.

Keeping these records together makes it easier to prepare for appointments, share current information with new care teams, and quickly locate important results and treatment plans when they are needed most.

Within this specialty, file the newest records at the front so the most current information is always easy to find.



Your child. Your records. Your voice. Always with you.



ENDOCRINOLOGY CLINIC

Specialty Profile

This page provides an enduring overview of your child's endocrine care.
Update only when information changes significantly.

CARE TEAM

Primary Endocrinologist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____

ENDOCRINE INFORMATION

Primary Endocrine Diagnosis _____

Date Diagnosed _____

Current Steroid Regimen _____

Growth / Puberty Concerns _____

☐ Bone Health Monitoring

☐ Vitamin D / Calcium

☐ Diabetes Screening

☐ Adrenal Plan on File

Last DEXA / Bone Density _____

ONGOING CARE SERVICES

☐ Endocrinology Follow-Up

☐ Social Work / Case Management

☐ Nutrition / Dietetics

☐ Mental Health Support

☐ Bone Health Clinic

☐ Palliative Care

☐ Physical Therapy

☐ Other

MONITORING / SUPPORTS

☐ Growth Tracking

☐ Adrenal Insufficiency Plan

☐ Blood Glucose Monitoring

☐ Emergency Steroid Card

☐ Vitamin D / Calcium

☐ Puberty / Hormone Support

☐ DEXA / Bone Density

☐ Other

BASELINE HEALTH STATUS

☐ Growth within expected range

☐ Low bone density

☐ Weight concerns

☐ Blood sugar concerns

☐ Delayed puberty

☐ Adrenal insufficiency risk

☐ Fracture history

☐ Thyroid concerns

! ALLERGIES / PRECAUTIONS

LONG-TERM CARE GOALS

? IMPORTANT PERMANENT NOTES



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's endocrine care at a glance, no matter when or where care is provided.

TIP:

Review this page at least once a year or when major changes occur.



ENDOCRINOLOGY CLINIC

Visit Summary

Keep a summary of each visit to track endocrine care, recommendations, and next steps.
File visit summaries in chronological order with the newest at the front.

VISIT INFORMATION

Visit Date _____

Provider _____

Clinic / Location _____

Care Team Present _____

Visit Type

☐ Routine Follow-Up

☐ New Patient

☐ Procedure

☐ Bone Health

☐ Growth / Puberty

☐ Other

Next Visit Date _____

VISIT SUMMARY

Reason for Visit

Summary of Visit / Findings

Recommendations / Plan

Orders / Referrals / Tests

Medications / Treatment Changes

Notes



Keep the newest records at the front.



Your child. Your records. Your voice. Always with you.

LAST REVISION DATE

___ / ___ / ___



ORTHOPEDICS



PROVIDER INFORMATION

Primary Orthopedic Provider _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Orthopedic evaluations
- ☒ X-ray / imaging reports
- ☒ Mobility / gait assessments
- ☒ Casting / splinting records
- ☒ Bracing / orthotics notes
- ☒ Surgical consultations
- ☒ Operative reports
- ☒ Post-op follow-up notes
- ☒ Equipment recommendations
- ☒ Care recommendations
- ☒ Other Orthopedic Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



ORTHOPEDICS

Specialty Profile

This page provides an enduring overview of your child's orthopedic care.
Update only when information changes significantly.



CARE TEAM

Primary Orthopedic Provider _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



ORTHOPEDIC INFORMATION

Primary Diagnosis / Concern _____

Affected Area(s) _____

Date Orthopedic Care Began _____

Last Imaging Date _____

Current Weight-Bearing Status _____

Current Braces / Orthotics
☐ Yes ☐ No If yes, which _____

Recent Surgery / Procedure _____

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Orthopedics | ☐ Cardiac Surveillance |
| ☐ Physical Therapy | ☐ Palliative Care |
| ☐ Occupational Therapy | ☐ Mental Health Support |
| ☐ Neuromuscular Clinic | ☐ Other |
| ☐ Pulmonary Surveillance | ☐ Other |

Equipment currently used:

- | | |
|--|---|
| ☐ Manual Wheelchair | ☐ Braces / Orthotics |
| ☐ Power Wheelchair | ☐ Shower Chair / Commode |
| ☐ Standing Device | ☐ Communication Device |
| ☐ Walker / Gait Trainer | ☐ Other |
| ☐ Lift / Transfer Aid | ☐ Other |

Current baseline (check all that apply):

- | | |
|--|---|
| ☐ Walks independently | ☐ Transfers independently |
| ☐ Uses braces regularly | ☐ Requires help with ADLs |
| ☐ Requires assistance for walking | ☐ Pain affects function |
| ☐ Uses wheelchair | ☐ Recent falls / instability |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's orthopedic needs, equipment, goals, and precautions.



TIP:

Review this page at least once a year or when major changes occur.



ORTHOPEDICS

Visit Summary

Keep a summary of each visit to track care, recommendations, and next steps.
File visit summaries in chronological order with the newest at the front.



VISIT INFORMATION

Visit Date _____

Provider _____

Clinic / Location _____

Care Team Present _____

Visit Type

☐ Routine Follow-Up ☐ New Patient ☐ Procedure

☐ Other _____

Next Visit Date _____



VISIT SUMMARY

Reason for Visit _____

Summary of Visit / Findings _____

Recommendations / Plan _____

Orders / Referrals / Tests _____

Bracing / Equipment / Treatment Changes _____

Notes _____



TIP: Keep the newest orthopedic records at the front.



Your child. Your records. Your voice. Always with you.

LAST REVISION DATE

____ / ____ / ____



NUTRITION & DIETETICS



PROVIDER INFORMATION

Primary Dietitian / Nutritionist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Nutrition assessments
- ☒ Growth charts
- ☒ Diet plans
- ☒ Feeding evaluations
- ☒ Laboratory results
- ☒ Formula / supplement orders
- ☒ Swallow study reports
- ☒ Tube-feeding records
- ☒ Medication changes
- ☒ Care recommendations
- ☒ Other Nutrition & Dietetics Records
- ☐ _____
- ☐ _____



Keep the newest records at the front of this section.



NUTRITION & DIETETICS

Specialty Profile

This page provides an enduring overview of your child's nutrition and feeding care.
Update only when information changes significantly.



CARE TEAM

Primary Dietitian / Nutritionist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



NUTRITION INFORMATION

Primary Nutrition Concerns _____

Current Diet / Formula _____

Date Nutrition Care Began _____

Current Weight _____

Current Height _____

Feeding Tube
☐ Yes ☐ No If yes, type _____

Food Allergies / Intolerances _____



LONG-TERM CARE SERVICES

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Nutrition / Dietetics | ☐ Social Work / Case Management |
| ☐ Feeding Therapy | ☐ Mental Health Support |
| ☐ Speech / Swallow Therapy | ☐ Home Health / Nursing |
| ☐ Gastroenterology | ☐ Palliative Care |
| ☐ Endocrinology | ☐ Other |



NUTRITION SUPPORTS & EQUIPMENT

Nutrition supports currently used:

- | | |
|--|---|
| ☐ Feeding Pump | ☐ Positioning Supports |
| ☐ Feeding Tube Supplies | ☐ Thickened Liquids |
| ☐ Specialized Formula | ☐ Suction Equipment |
| ☐ Oral Supplements | ☐ Other |
| ☐ Adaptive Utensils | ☐ Other |



BASELINE NUTRITION STATUS

Current baseline (check all that apply):

- | | |
|--|---|
| ☐ Eats by mouth independently | ☐ Uses feeding tube partly |
| ☐ Needs help with meals | ☐ Uses feeding tube fully |
| ☐ Uses modified diet | ☐ Swallowing concerns |
| ☐ Uses oral supplements | ☐ Constipation / reflux concerns |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's nutrition needs, feeding supports, goals, and precautions.



TIP:

Review this page at least once a year or when major changes occur.



NUTRITION & DIETETICS

Visit Summary

Keep a summary of each visit to track nutrition status, recommendations, and next steps.
File visit summaries in chronological order with the newest at the front.



VISIT INFORMATION

Visit Date _____

Provider _____

Clinic / Location _____

Care Team Present _____

Visit Type

☐ Routine Follow-Up ☐ New Patient ☐ Feeding Assessment

☐ Other _____

Next Visit Date _____



VISIT SUMMARY

Reason for Visit

Nutrition Status / Findings

Recommendations / Plan

Labs / Tests / Referrals

Diet / Formula / Feeding Changes

Notes



TIP: Keep the newest nutrition records at the front.



Your child. Your records. Your voice. Always with you.

LAST REVISION DATE

____ / ____ / ____



PHYSICAL MEDICINE & REHABILITATION



PROVIDER INFORMATION

Primary PM&R Provider _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ PM&R evaluations
- ☒ Functional assessments
- ☒ Mobility / gait assessments
- ☒ Spasticity management notes
- ☒ Bracing / orthotics recommendations
- ☒ Equipment evaluations
- ☒ Rehabilitation therapy plans
- ☒ Pain management notes
- ☒ Procedure notes
- ☒ Care recommendations
- ☒ Other PM&R Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



PHYSICAL MEDICINE & REHABILITATION

Specialty Profile

This page provides an enduring overview of your child's PM&R care.
Update only when information changes significantly.



CARE TEAM

Primary PM&R Provider _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



REHABILITATION INFORMATION

Primary Diagnosis / Concern _____

Primary Functional Goals _____

Date PM&R Care Began _____

Last PM&R Visit _____

Current Mobility Status _____

Spasticity Management
☐ Yes ☐ No If yes, type _____

Current Braces / Orthotics _____

Services currently part of ongoing care:

- | | |
|---|---|
| ☐ PM&R | ☐ Neuromuscular Clinic |
| ☐ Physical Therapy | ☐ Pulmonary Surveillance |
| ☐ Occupational Therapy | ☐ Palliative Care |
| ☐ Speech Therapy | ☐ Mental Health Support |
| ☐ Orthopedics | ☐ Other |

Equipment currently used:

- | | |
|--|---|
| ☐ Manual Wheelchair | ☐ Shower Chair / Commode |
| ☐ Power Wheelchair | ☐ Orthotics / Bracing |
| ☐ Standing Device | ☐ Communication Device |
| ☐ Walker / Gait Trainer | ☐ Other |
| ☐ Lift / Transfer Aid | ☐ Other |

Current baseline (check all that apply):

- | | |
|---|---|
| ☐ Walks independently | ☐ Independent in daily activities |
| ☐ Requires assistance to walk | ☐ Requires assistance for ADLs |
| ☐ Uses wheelchair | ☐ Uses communication support |
| ☐ Transfers independently | ☐ Pain or spasticity limits function |
| ☐ Requires help with transfers | ☐ Feeds independently |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's PM&R needs, equipment, functional goals, and precautions.



TIP:

Review this page at least once a year or when major changes occur.



PHYSICAL MEDICINE & REHABILITATION

our most recent
nmaries at the
this section.

Visit Summary

Use this page to capture key information from each visit.
Place this summary at the front of the visit records in this section.

Visit Date _____

Provider _____

Reason for Visit _____

TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|---|--|
| ☐ Functional assessment | ☐ Spasticity assessment |
| ☐ Range of motion | ☐ Equipment evaluation |
| ☐ Mobility / gait assessment | ☐ Bracing / orthotics eval |
| ☐ Strength assessment | ☐ Imaging (X-ray / MRI / Other) |
| ☐ Pain assessment | ☐ Other |

See visit records for details and results.



KEY FINDINGS

Summary of important findings from this visit.

CHANGES OR UPDATES

MEDICATION CHANGES

- ☐ New Medication
☐ Dose Change
☐ Discontinued

Details: _____

THERAPY / TREATMENT CHANGES

- ☐ New Therapy
☐ Change in Frequency
☐ Discontinued

Details: _____

EQUIPMENT / SUPPLY CHANGES

- ☐ New Equipment
☐ Equipment Adjustment
☐ Repairs / Replacement

Details: _____

OTHER CHANGES

- ☐ Care Plan Update
☐ Activity / Restrictions
☐ Other

Details: _____

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place the clinic note, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





PAIN MANAGEMENT



PROVIDER INFORMATION

Primary Pain Management Provider _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Pain management evaluations
- ☒ Pain assessments / scales
- ☒ Medication records
- ☒ Procedure notes
- ☒ Imaging reports
- ☒ Therapy recommendations
- ☒ Complementary treatment notes
- ☒ Hospital discharge summaries
- ☒ Progress notes
- ☒ Care recommendations
- ☒ Other Pain Management Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



PAIN MANAGEMENT

Specialty Profile

This page provides an enduring overview of your child's pain management care.
Update only when information changes significantly.



CARE TEAM

Primary Pain Management Provider _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



PAIN INFORMATION

Primary Pain Diagnosis / Concern _____

Pain Location(s) _____

Date Pain Care Began _____

Typical Pain Level (0-10) _____

Pain Triggers _____

Breakthrough Pain Plan
☐ Yes ☐ No Last updated _____

Current Pain Medications _____

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Pain Management | ☐ Neuromuscular Clinic |
| ☐ Physical Therapy | ☐ Orthopedics |
| ☐ Occupational Therapy | ☐ Integrative Therapies |
| ☐ Behavioral Health | ☐ Social Work / Case Management |
| ☐ Palliative Care | ☐ Other |

Pain supports currently used:

- | | |
|--|---|
| ☐ Positioning Supports | ☐ Massage / Stretching |
| ☐ Pressure Relief Cushion | ☐ Sleep Positioning |
| ☐ Heat / Cold Therapy | ☐ Mobility Equipment |
| ☐ TENS Unit | ☐ Other |
| ☐ Braces / Orthotics | ☐ Other |

Current baseline (check all that apply):

- | | |
|--|--|
| ☐ Pain absent at rest | ☐ Pain limits mobility |
| ☐ Pain with activity | ☐ Needs help with transfers |
| ☐ Pain affects sleep | ☐ Uses positioning support |
| ☐ Pain affects mood | ☐ Uses rescue medication |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's pain patterns, treatments, goals, and safety considerations.



TIP:

Review this page at least once a year or when major changes occur.



PAIN MANAGEMENT

Visit Summary

Use this page to capture key information from each pain management visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

ASSESSMENTS & EVALUATIONS

(Check all that apply)

- | | |
|---|---|
| ☐ Pain scale assessment | ☐ Medication review |
| ☐ Physical exam | ☐ Imaging review |
| ☐ Functional assessment | ☐ Procedure evaluation |
| ☐ Sleep assessment | ☐ Caregiver interview |
| ☐ Mood / coping assessment | ☐ Other |

See pain management records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

MEDICATION CHANGES

- ☐ New Medication
- ☐ Dose Change
- ☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

PROCEDURE / TREATMENT CHANGES

- ☐ New Procedure
- ☐ Therapy Change
- ☐ Home Plan Updated

Details: _____



EQUIPMENT / SUPPLY CHANGES

EQUIPMENT / SUPPORT CHANGES

- ☐ New Equipment
- ☐ Positioning Change
- ☐ Supply Adjustment

Details: _____



OTHER CHANGES

OTHER CHANGES

- ☐ Care Plan Update
- ☐ Activity / Restrictions
- ☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Questions I Still Have

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
- ☐ Patient
- ☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place clinic notes, test results, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





BEHAVIORAL HEALTH



PROVIDER INFORMATION

Primary Behavioral Health Provider _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Therapy / counseling notes
- ☒ Psychiatric evaluations
- ☒ Psychological testing
- ☒ Treatment plans
- ☒ Medication records
- ☒ Crisis / safety plans
- ☒ School / behavior plans
- ☒ Hospital discharge summaries
- ☒ Progress notes
- ☒ Care recommendations
- ☒ Other Behavioral Health Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



BEHAVIORAL HEALTH

Specialty Profile

This page provides an enduring overview of your child's behavioral health care.
Update only when information changes significantly.



CARE TEAM

Primary Behavioral Health Provider _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



2

DIAGNOSIS INFORMATION

Primary Diagnosis / Concern _____

Co-occurring Diagnoses _____

Date Care Began _____

Current Therapy Frequency _____

School / Work Setting _____

Crisis / Safety Plan
☐ Yes ☐ No Last updated _____

Current Medications _____

Services currently part of ongoing care:

- | | |
|---|--|
| ☐ Individual Counseling | ☐ Social Work / Case Management |
| ☐ Family Therapy | ☐ Peer Support |
| ☐ Psychiatry | ☐ Crisis Services |
| ☐ Psychology / Neuropsychology | ☐ Palliative Care |
| ☐ School Counseling | ☐ Other |

Supports currently used:

- | | |
|---|--|
| ☐ School / Work Plan | ☐ Crisis Contacts |
| ☐ Behavior Support Plan | ☐ Safety Plan |
| ☐ Sensory Supports | ☐ Caregiver Support |
| ☐ Communication Supports | ☐ Other |
| ☐ Sleep Routine Plan | ☐ Other |

Current baseline (check all that apply):

- | | |
|--|--|
| ☐ Mood generally stable | ☐ Needs help with transitions |
| ☐ Manages anxiety with support | ☐ Sleep concerns |
| ☐ Communicates emotions | ☐ Behavioral outbursts |
| ☐ Participates in school / work | ☐ Safety concerns |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's behavioral health needs, supports, goals, and safety considerations.



TIP:

Review this page at least once a year or when major changes occur.





BEHAVIORAL HEALTH

Visit Summary

Use this page to capture key information from each behavioral health visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____

ASSESSMENTS & EVALUATIONS

(Check all that apply)

- | | |
|---|---|
| ☐ Mental status exam | ☐ Medication review |
| ☐ Depression screening | ☐ Family / caregiver interview |
| ☐ Anxiety screening | ☐ School / work functioning |
| ☐ Suicide risk screening | ☐ Sleep assessment |
| ☐ Behavioral assessment | ☐ Other |

See behavioral health records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

MEDICATION CHANGES

- ☐ New medication
☐ Dose change
☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

THERAPY / TREATMENT CHANGES

- ☐ New therapy goal
☐ Change in frequency
☐ New treatment approach

Details: _____



EQUIPMENT / SUPPLY CHANGES

SAFETY / SUPPORT PLAN CHANGES

- ☐ Safety plan updated
☐ School / work support
☐ Caregiver support

Details: _____



OTHER CHANGES

OTHER CHANGES

- ☐ Care plan update
☐ Activity / restrictions
☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
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Questions I Still Have

☐ _____
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ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
☐ Patient
☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place visit notes, assessments, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





SPEECH THERAPY



PROVIDER INFORMATION

Primary Speech-Language Pathologist _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

☒ Speech / language evaluations

☒ Swallow study reports

☒ Feeding evaluations

☒ Communication assessments

☒ AAC evaluations

☒ Therapy plans and goals

☒ Progress notes

☒ Home exercise programs

☒ Equipment recommendations

☒ Care recommendations

☒ Other Speech Therapy Records

☐ _____

☐ _____



Keep the newest records at the front of this section.



SPEECH THERAPY

Specialty Profile

This page provides an enduring overview of your child's speech, language, and swallowing care.
Update only when information changes significantly.



CARE TEAM

Primary Speech-Language Pathologist _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



SPEECH & SWALLOW INFORMATION

Primary Communication Concern _____

Primary Swallowing Concern _____

Date Therapy Began _____

Current Therapy Frequency _____

School / Work Setting _____

Uses AAC / Communication Device
☐ Yes ☐ No If yes, type _____

Current Diet / Liquid Texture _____

Services currently part of ongoing care:

- | | |
|---|---|
| ☐ Speech Therapy | ☐ Nutrition / Dietetics |
| ☐ Feeding Therapy | ☐ School-Based Services |
| ☐ Occupational Therapy | ☐ Pulmonary Surveillance |
| ☐ Physical Therapy | ☐ Palliative Care |
| ☐ Gastroenterology | ☐ Other |

Communication / feeding supports used:

- | | |
|--|--|
| ☐ AAC Device | ☐ Modified Diet |
| ☐ Communication Board | ☐ Thickened Liquids |
| ☐ Switch Access | ☐ Feeding Tube |
| ☐ Voice Amplifier | ☐ Other |
| ☐ Adaptive Utensils | ☐ Other |

Current baseline (check all that apply):

- | | |
|---|---|
| ☐ Speech is understandable | ☐ Eats by mouth |
| ☐ Uses communication support | ☐ Needs texture modification |
| ☐ Communicates wants / needs | ☐ Has swallowing concerns |
| ☐ Follows directions | ☐ Uses feeding tube |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of your child's communication, swallowing, feeding, and support needs.



TIP:

Review this page at least once a year or when major changes occur.



SPEECH THERAPY

Visit Summary

Use this page to capture key information from each speech therapy visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|--|---|
| ☐ Speech assessment | ☐ AAC / communication assessment |
| ☐ Language assessment | ☐ Oral-motor assessment |
| ☐ Swallow assessment | ☐ Cognitive-communication assessment |
| ☐ Feeding assessment | ☐ Home / school communication review |
| ☐ Voice assessment | ☐ Other |

See therapy records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

THERAPY / TREATMENT CHANGES

- ☐ New therapy goal
- ☐ Change in frequency
- ☐ Home program updated

Details: _____



THERAPY / TREATMENT CHANGES

COMMUNICATION SUPPORT CHANGES

- ☐ New AAC support
- ☐ Device adjustment
- ☐ New communication strategy

Details: _____



EQUIPMENT / SUPPLY CHANGES

FEEDING / SWALLOW CHANGES

- ☐ Diet texture change
- ☐ Liquid consistency change
- ☐ New feeding strategy

Details: _____



OTHER CHANGES

OTHER CHANGES

- ☐ Care plan update
- ☐ Activity / restrictions
- ☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____

☐ _____

☐ _____

☐ _____

Questions I Still Have

☐ _____

☐ _____

☐ _____

☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

- ☐ Parent / Caregiver
- ☐ Patient
- ☐ Other _____

Date Completed _____



TIP: Complete this summary during or right after the visit while information is fresh.
Then place therapy notes, evaluations, and other documents behind this page.

LAST REVISION DATE

____ / ____ / ____





OTHER SPECIALTIES



PROVIDER INFORMATION

Specialty / Provider _____

Clinic / Hospital _____

Phone _____

Next Appointment _____

Other Providers _____

BEHIND THIS DIVIDER, FILE:

- ☒ Consultation notes
- ☒ Specialist evaluations
- ☒ Diagnostic test results
- ☒ Imaging reports
- ☒ Laboratory results
- ☒ Treatment plans
- ☒ Procedure / surgery records
- ☒ Medication changes
- ☒ Hospital discharge summaries
- ☒ Care recommendations
- ☒ Other Specialty Records







Keep the newest records at the front of this section.



OTHER SPECIALTIES

Specialty Profile

Use this page for any specialist not covered elsewhere in your child's care binder.
Update only when information changes significantly.



CARE TEAM

Specialty / Provider _____

Clinic / Hospital _____

Phone _____

Care Coordinator _____

Phone _____

Clinic Website _____



SPECIALTY INFORMATION

Specialty _____

Primary Diagnosis / Concern _____

Date Care Began _____

Reason for Referral _____

Current Treatment Plan _____

Active Follow-Up
☐ Yes ☐ No Frequency _____

Current Medications _____

Services currently part of ongoing care:

- | | |
|---|---|
| ☐ Primary Care | ☐ Physical Therapy |
| ☐ Neuromuscular Clinic | ☐ Occupational Therapy |
| ☐ Cardiology | ☐ Behavioral Health |
| ☐ Pulmonology | ☐ Palliative Care |
| ☐ Gastroenterology | ☐ Other |

Equipment or supports currently used:

- | | |
|---|---|
| ☐ Manual Wheelchair | ☐ Braces / Orthotics |
| ☐ Power Wheelchair | ☐ Medical Supplies |
| ☐ Standing Device | ☐ Home Equipment |
| ☐ Lift / Transfer Aid | ☐ Other |
| ☐ Communication Device | ☐ Other |

Current baseline (check all that apply):

- | | |
|---|--|
| ☐ Condition stable | ☐ Has activity restrictions |
| ☐ Requires regular follow-up | ☐ Has safety precautions |
| ☐ Uses adaptive equipment | ☐ Recent hospitalization |
| ☐ Needs caregiver assistance | ☐ Recent change in function |



ALLERGIES / PRECAUTIONS



LONG-TERM CARE GOALS

Our long-term goals for care:



IMPORTANT PERMANENT NOTES

Important information every provider should know:



WHY THIS MATTERS

This profile gives any provider a quick understanding of this specialist's role, treatment plan, equipment, and important precautions.



TIP:

Review this page at least once a year or when major changes occur.



OTHER SPECIALTIES

Visit Summary

Use this page to capture key information from each specialist visit.
Place this summary at the front of the visit records in this section.



Keep your most recent
visit summaries at the
front of this section.



Visit Date _____



Provider _____



Clinic / Location _____

Reason for Visit _____



TESTS & EVALUATIONS PERFORMED

TESTS & EVALUATIONS PERFORMED

(Check all that apply)

- | | |
|---|--|
| ☐ Physical exam | ☐ Functional assessment |
| ☐ Laboratory tests | ☐ Medication review |
| ☐ Imaging | ☐ Caregiver interview |
| ☐ Diagnostic testing | ☐ Other _____ |
| ☐ Procedure | ☐ Other _____ |

See specialty records for details and results.



KEY FINDINGS

Summary of important findings from this visit.



CHANGES OR UPDATES



MEDICATION CHANGES

MEDICATION CHANGES

- ☐ New medication
☐ Dose change
☐ Discontinued

Details: _____



THERAPY / TREATMENT CHANGES

TREATMENT PLAN CHANGES

- ☐ New treatment
☐ Change in frequency
☐ Procedure planned

Details: _____



EQUIPMENT / SUPPLY CHANGES

EQUIPMENT / SUPPORT CHANGES

- ☐ New equipment
☐ Adjustment / repair
☐ New support

Details: _____



OTHER CHANGES

OTHER CHANGES

- ☐ Care plan update
☐ Activity / restrictions
☐ Other

Details: _____



FOLLOW-UP PLAN

Next Appointment Date _____

With _____

Recommended Tests / Referrals _____

Other Instructions / Recommendations _____



QUESTIONS

Questions Answered

☐ _____
☐ _____
☐ _____
☐ _____

Questions I Still Have

☐ _____
☐ _____
☐ _____
☐ _____



ADDITIONAL NOTES



INFORMATION SOURCE

This summary was completed by:

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☐ Patient
☐ Other _____

Date Completed _____



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LAST REVISION DATE

____ / ____ / ____

