Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

This document should be shared with and carried by the young adult.		
Date Completed:	Date Revised:	
Form completed by:		
Contact Information		
Name:	Nickname:	
DOB:	Preferred Language:	
Address:		
Cell #: Home #:	Best Time to Reach:	
E-Mail:	Best Way to Reach: Text Phone Email	
Health Insurance/Plan:	Group and ID #:	
Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		

Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations

Special Concerns for Disaster:	
Allergies and Procedures to be Avoided	
Allergies	Reactions
To be avoided	Why?
☐ Medical Procedures:	
☐ Medications:	
Diagnoses and Current Problems	
Problem	Details and Recommendations
☐ Primary Diagnosis	
☐ Secondary Diagnosis	
☐ Behavioral	
☐ Communication	
☐ Feed & Swallowing	
☐ Hearing/Vision	
☐ Learning	
☐ Orthopedic/Musculoskeletal	
☐ Physical Anomalies	
☐ Respiratory	
☐ Sensory	
☐ Stamina/Fatigue	
☐ Other	

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Medications					
Medications	Dose	Frequency	Medications	Dose	Frequency

Health Care Providers				
Provider	Primary and Specialty	Clinic or Hospital	Phone	Fax

Prior Surgeries, Procedures, and Hospitalizations	
Date	
Date	
Date	
Date	
Date	

Baseline					
Baseline Vital Signs:	Ht	Wt	RR	HR	BP
Baseline Neurological Status:					

Most Recent Labs and Radiology		
Test	Date	Result
EEG		
EKG		
X-Ray		
C-Spine		
MRI/CT		
Other		
Other		

Equipment, Appliances, and Assistive Technology			
☐ Gastrostomy	☐ Adaptive Seating		☐ Wheelchair
☐ Tracheostomy	☐ Communication Device		☐ Orthotics
☐ Suctions	Monitors:		☐ Crutches
☐ Nebulizer	☐ Apnea	☐ 02	☐ Walker
	☐ Cardiac	☐ Glucose	
☐ Other			

School, Work and Community Information		
Agency/School	Contact Information	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

Special information that the patient wants health care professionals to know

_____

Patient/Guardian signature Print Name Phone Number Date

_____

Primary Care Provider Signature Print Name Phone Number Date

_____

Care Coordinator Signature Print Name Phone Number Date

Please attach the immunization record to this form.