Pediatric to Adult Care Transitions Tools

Medical Summary & Emergency Care Plan for *Young Adults with Intellectual/Developmental Disabilities*

This document should be completed by medical providers, in collaboration with youth and their caregivers. A copy of this completed document should be shared with and carried by youth and caregivers to facilitate comprehensive information transfer and chart review when establishing care with new medical providers.

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
Parent (Caregiver):	**Relationship:**
Address:	
Cell #: **Home #:**	**Best Time to Reach:**
E-Mail:	**Best Way to Reach:** Text Phone Email
Health Insurance/Plan:	**Group and ID #:**

Please add special information about strengths that the youth/caregiver wants their new health care team to know:

Developmental Disability

☐ Verbal ☐ Non-Verbal

Nervous System:

- ☐ Autism spectrum disorder
- ☐ Cerebral palsy
- ☐ Down syndrome
- ☐ Fetal Alcohol Syndrome
- ☐ Fragile X
- ☐ Intellectual disability
- ☐ Rett syndrome
- ☐ Spina bifida
- ☐ Tourette syndrome
- ☐ Other (Specify):

Sensory System:

	Avoidant	Seeking	Impaired
Visual	☐	☐	☐
Auditory	☐	☐	☐
Gustatory	☐	☐	☐
Olfactory	☐	☐	☐
Tactile	☐	☐	☐
Proprioceptive	☐	☐	☐
Vestibular	☐	☐	☐

Other (Specify):

Other:

- ☐ ADHD
- ☐ Hearing impairment
- ☐ Visual impairment
- ☐ Seizures
- ☐ Cardiac Condition
- ☐ Obesity
- ☐ OSA
- ☐ Other (Specify):

Degenerative:

- ☐ Muscular dystrophy
- ☐ Other (Specify):

Co-occurring Psychological Issues:

- ☐ Depression
- ☐ Aggression
- ☐ Anxiety
- ☐ Relational
- ☐ Self-injurious Beahvior
- ☐ Other (Specify):

Metabolism:

- ☐ Congenital hypothyroidism
- ☐ Phenylketonuria
- ☐ Other (Specify):

Etiology

- ☐ Genetic/Chromosomal
- ☐ Preterm Birth
- ☐ Prenatal Substance Exposure
- ☐ Birth Complication
- ☐ Prenatal Viral Exposure
- ☐ Acquired or Traumatic Brain Injury

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☐ Other		
Adaptive Functioning Domains		
Communication:		
Social:		
Self Direction:		
Community Activities:		
Work:		
Functional Academics:		
Functional Grade Level:	**Date Tested:**	
FSIQ:	**Date Tested:**	
Home Living:		
Leisure:		
Sleep Issues:		
Nutritional Issues:		
Quality of Life Issues:		
Safety Issues:		
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			
	Name	**Phone**	**Fax**
Primary Care Provider			
Specialty Provider (if			
Specialty Provider (if			
Specialty Provider (if			
Clinic or Hospital Provider(s)			
Speech Therapist			
Physical Therapist			
Occupational Therapist			
Mental Health/Psychiatry			
Other			

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 (Specify):		

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Equipment, Appliances, and Assistive Technology			
☐ Gastrostomy	☐ Adaptive Seating		☐ Wheelchair
☐ Tracheostomy	☐ Communication Device		☐ Orthotics
☐ Suctions	☐ Monitors:		☐ Crutches
☐ Nebulizer	Apnea	O2	☐ Walker
	Cardiac	Glucose	
☐Other (Specify):			

School and Community Information		
Agency/School	**Contact Information**	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

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