# MEDICAL SUMMARY: TRANSITIONING PATIENT

## YOUNG ADULTS WITH NEUROLOGIC DISORDERS

**Instructions:** This document should be completed by medical providers, in collaboration with youth and their caregivers.

**Intent:** This document should be shared with the transitioning patient's new medical providers, as well as the patient himself/herself and his/her caregivers, as appropriate.

| **Patient Information** | | | |
|---|---|---|---|
| Patient Name: | | | |
| Date Form First Completed: | | | |
| Date/s Form Revised: | | | |
| Form Completed by: | | | |
| **Principal Transition Medical Provider's Contact Information** | | | |
| Name: | | | |
| Address: | | | |
| Work number: | Best Time to Reach: | | |
| Email: | Best Way to Reach: Phone Email | | |
| **Transitioning Patient Contact and Insurance Information** | | | |
| Name: | Nickname: | | |
| DOB: | Preferred Language: | | |
| Address: | | | |
| Cell #: | Home #: | Best Time to Reach: | |
| Email: | | Best Way to Reach: Text Phone Email | |
| Parent (Caregiver): | Relationship: | | |
| Address: | | | |
| Cell #: | Home #: | Best Time to Reach: | |
| Email: | | Best Way to Reach: Text Phone Email | |
| Health Insurance Plan: | Group and ID | | |
| Limited Legal Status? (Y/N) | Tutorship (Y/N) | Guardianship Y/N | |
| ****Legal documents to be provided by parents of primary caregivers** Please attach.** | | | |

 

## Health Care Providers

| | Name | Phone/Fax | Email |
|---|---|---|---|
| Primary Care Provider | | | |
| | **Specialty & Name** | **Phone/Fax** | **Email** |
| Specialty Provider | | | |
| Specialty Provider | | | |
| Specialty Provider | | | |
| Specialty Provider | | | |
| Specialty Provider | | | |
| | **Name** | **Phone/Fax** | **Email** |
| Occupational Therapist | | | |
| Physical Therapist | | | |
| Speech Therapist | | | |
| Behavioral Health | | | |
| Other | | | |
| Other | | | |
| Other | | | |

## School and Community Information

| Agency/School | Contact Person | Phone/Fax | Email |
|---|---|---|---|
| | | | |
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## Emergency Care Plan

| | | | | | |
|---|---|---|---|---|---|
| Name | | | | Relationship to Patient | |
| Phone (Cell) | | Phone (Other) | | Email | |
| Preferred Emergency Care Location | | | | | |
| Special precautions (eg, seizure action plan) | | | | | |

## Etiology (Check all that apply; describe)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Genetic/Chromosomal | ☐ | Prenatal Substance Exposure | ☐ | Prenatal Viral Exposure |
| ☐ | Preterm Birth | ☐ | Infection | ☐ | Acquired (eg, TBI, Submersion injury) |
| ☐ | Metabolic | ☐ | Other (specify) | ☐ | Other (specify) |
| ☐ | Unknown (specify) | | | | |

## Diagnoses and Current Problem

***Primary Neurological Diseases***

| **Problem List** | **Details and Recommendations** |
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***Secondary Diagnoses***

| **Problem List** | **Details and Recommendations** |
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***Associated Behavioral Issues***

| | |
|---|---|
| Please specify: | |

## Allergies; Medications and Procedures to be Avoided

| ***Allergies*** | ***Reactions*** |
|---|---|
| | |
| | |
| ***Avoid*** | ***Why?*** |
| **Medications (List)** | |
| **Medical Procedures (List)** | |
| | |

| Current Medications (For prior medications, please complete final page) | | | | | |
|---|---|---|---|---|---|
| **Medications** | **Dose** | **Frequency** | **Medications** *(continued)* | **Dose** | **Frequency** |
| 1. | | | 7. | | |
| 2. | | | 8. | | |
| 3. | | | 9. | | |
| 4. | | | 10 | | |
| 5. | | | 11. | | |
| 6. | | | 12. | | |

| Prior Surgeries, Procedures and Hospitalizations (include imagery where available) | |
|---|---|
| **Date:** | |
| **Date:** | |
| **Date:** | |
| **Date:** | |
| **Date:** | |
| **Date:** | |
| **Date:** | |
| **Date:** | |

| Adaptive Functioning Domains (current activities) | | | | |
|---|---|---|---|---|
| **Communication** | **Verbal?** | **NonVerbal?** | | |
| **Social** | | | | |
| **Nutritional Issues** | | | | |
| **Sleep Issues** | | | | |
| **Mobility** | **Independent?** | **Aides?** | **Wheelchair?** | |
| | **Other? Describe** | | | |
| **Functional Academics** | **Functional Grade Level:** | | **Date Tested:** | |
| | **FSIQ: (full-scale if available)** | | **Date Tested:** | |
| **Self-care** | | | | |
| **Leisure** | | | | |
| **Work** | | | | |
| **Community Activities** | | | | |
| **Safety Issues** | | | | |
| **Additional Information** | | | | |
| | | | | |
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| Equipment, Appliances, and Assistive Technology (note all that apply) | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Gastrostomy | ☐ | Communication Device | Monitors | | ☐ | Other, Describe: |
| ☐ | Tracheostomy | ☐ | Wheelchair | ☐ | Apnea | | |
| ☐ | Suctions | ☐ | Orthotics | ☐ | Cardiac | | |
| ☐ | Nebulizer | ☐ | Crutches | ☐ | Oxygen | | |
| ☐ | Adaptive Seating | ☐ | Walker | ☐ | Glucose | | |

| Additional Notes or Information Not Covered Above |
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| Signatures | | | |
|---|---|---|---|
| **Parent/Guardian Name** *(Printed)* | | | |
| **Parent/Guardian Name** *(Signature)* | | | |
| **Phone Number** | | **Date** | |
| | | | |
| **Primary Care Provider Name** *(Printed)* | | | |
| **Primary Care Provider Name** *(Signature)* | | | |
| **Phone Number** | | **Date** | |
| | | | |
| **Neurology Provider Name** *(Printed)* | | | |
| **Neurology Provider Name** *(Signature)* | | | |
| **Phone Number** | | **Date** | |

| Prior Medications for Complex Medication Histories (eg, epilepsy) | | |
|---|---|---|
| **Medication** | **Duration** | **Reason Discontinued & Comments** |
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