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

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**

Secondary Diagnoses

Problem List	**Details and Recommendations**

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				

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

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**