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 I N ☐	Tutorship ☐ Y I N ☐	Guardianship ☐ Y I N ☐

****Legal documents to be provided by parents of primary caregivers** Please attach.**

Tool developed by the Child Neurology Foundation as part of the ACP HVC pediatric to adult care transition project.
Available at: **www.childneurologyfoundation.org/transitions**

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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 (e.g., seizure action plan):		

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Etiology (Check all that apply; describe)					
☐	Genetic/Chromosomal	☐	Prenatal Substance Exposure	☐	Prenatal Viral Exposure
☐	Preterm Birth	☐	Infection	☐	Acquired (e.g., 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)	

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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			

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Adaptive Functioning Domains (current activities)	
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

(continued)

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Signatures (continued)	
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 (e.g., epilepsy)		
Medication	Duration	Reason Discontinued & Comments