

Children's Health Status Assessment And Portable Medical Record "MY CHILD'S PROFILE"

I. PERSONAL INFORMATION

My Child's Name: _____ Nickname: _____

Date of Birth: _____ Social Security #: _____

Primary Language in our Home: _____ Date Form Completed: _____

Child Lives with: Biological Family Extended Family Adoptive Family Foster Family Group Home

• **Family/Care Providers Emergency Contacts:**

Name/Relationship	Home #	Work #	Cell Phone #	Pager #

Primary Care Provider (Pediatrician's name, address, phone, other numbers):

Clinical Care Coordinator: _____

Other Contacts at PCP office: _____

Case Manager: DDD: _____ Phone: _____ Other: _____
 Foster Care: _____ Phone: _____ Other: _____
 Other: _____ Phone: _____ Other: _____

• **Community Services we use:**

- WIC Contact Person: _____ Phone #: _____
- DDD Contact Person: _____ Phone #: _____
- CRS Contact Person: _____ Phone #: _____
- ALTCS Contact Person: _____ Phone #: _____
- Foster Care Contact Person: _____ Phone #: _____
- Raising Special Kids
 Contact Person: _____ Phone #: (602) 242-4366
- Respite Services
 Contact Person: _____ Phone #: _____
- Nursing Services
 Contact Person: _____ Phone #: _____
- CPS Contact Person: _____ Phone #: _____
- School Based Services
 Contact Person: _____ Phone #: _____

Other Contact Person: _____ Phone #: _____



• **Primary and Secondary Diagnosis:**

• **Insurance Information:**

If Arizona Long Term Care Services (ALTCS) or AHCCS of any type covers your child, it is considered secondary to any other insurance, trust funds, etc. Please advise us of any insurance you may have for your child to help us maximize your child's benefits and services.

Name, Social Security # and Employer of Insured: _____

Address if different from child's: _____

Primary Health Insurance/ Company _____

Billing/Correspondence Address _____

Policy Number _____

Phone Number _____

Secondary Health Insurance/ Company _____

Billing/Correspondence Address _____

Policy Number _____

Phone Number _____

Other Health Insurance/ Company _____

Billing/Correspondence Address _____

Policy Number _____

Phone Number _____



II. EQUIPMENT, SUPPLIES & SERVICES

- **Therapies and Related Services** Not applicable to my child

Therapy	Frequency	Provider	Phone #	Start Date
Physical				
Occupational				
Speech				
Other				

- **Medication/Equipment/Supplies Contacts** Not applicable to my child



Type	Provider	Address	Phone #	Start Date
Pharmacy				
Pharmacy				
Respiratory Medications				

Respiratory Supplies				
Nutritional/Enteral				
Durable Medical Equipment (DME)				
Mobility				
Ortho/AFO's				
Respiratory				
Positioning Aides				
Wheelchair				
Rehabilitation				
Assistive Tech				

• **Respiratory Care**

Not applicable to my child



Oxygen: Liters _____ Route _____ Start Date _____

SVN: Medication _____ Amount _____ Frequency _____

Suctioning: Route _____ Catheter size _____ Frequency _____

Tracheostomy: Size/Brand _____ Change frequency _____

Ventilator: Type _____ Settings: IMV _____ SIMV _____ Volume _____

Peak Pressure _____ PEEP _____ Rate _____

Pulse Ox: Type _____ Settings: Low Alarm _____ High Alarm _____

Apnea Monitor: Type _____ Settings: High Heart Rate _____ Low Heart Rate _____

Apnea setting in seconds _____

CPAP: Type _____ Settings: Pressure _____

Comments: _____



III. CURRENT STATUS OF SENSORY & ABILITY INFORMATION



• Vision:

Last Date tested: _____ By whom: _____ Where: _____

Results if known: _____

Glasses Contact lens Prosthesis Other _____

• Hearing:

Last Date tested: _____ By whom: _____ Where: _____

Test Type/Results: _____

Test Type/Results: _____

Wears aids Right ear Left ear Both ears



• Mobility / Orthotics:

Braces: Type _____ Orthotist _____ Provided by _____

Wheel Chair: Type _____ Orthotist _____ Provided by _____

Measured by _____ Last date measured _____

Walker: Type _____ Orthotist _____ Provided by _____

Jacket: Type _____ Orthotist _____ Provided by _____

• Communication:

- Computer Lip-reads
- Communication Board Interpreter Services
- Sign Language (ASL) Communication Book
- Sign Language (English) Other

• Developmental Screening:

At what age level is your child functioning: cognitively _____ motor skills _____

Date tested: _____ By whom: _____ Where: _____

• Ambulation:

- Walks independently Walks with assistance
- Walks with walker/brace etc Non-ambulatory
- Uses wheelchair with assist. Motorized
- Uses wheelchair w/o assist. Motorized



• Transfer Directions:

- Independent With assist Equipment type _____
- Pivot transfer 1 or 2 person lift Other _____

• Feeding:

- Regular diet No assist

- Soft Diet
- Pureed
- Finger foods
- Partial assist
- Total assist
- Feeding Pump
- Special dishes or utensils



• **Special Diet/ Instructions**

Not applicable to my child

Type	Route	Amount/Schedule	Start Date
Example Pediasure with Fiber	MIK-KEY Button	240cc bolus 4 X daily and 30cc from 9:00PM-6:00AM for a total of 4-5 cans daily	12/31/99

Comments:

• **Hygiene:**

- No assistance
- Partial assistance
- Totally assisted
- Bath chair or shower equipment



• **Toileting:**

- Fully toilet trained
- Diapers at night
- Diaper dependent
- No assistance
- Partial assistance
- Full assistance

Intermittent catheterization program
 Frequency _____ Technique _____
 Independent Needs assistance

Bowel management program

IV. ANCILLARY INFORMATION

Hospital typically used for CRS admission: _____ Non-CRS admission: _____

Advanced Directives No Yes, located where _____

Medical Power of Attorney No Yes, located where _____

Guardianship No Yes, Who (name) _____



• **Child's Ethnicity: (Please check all**

that apply)

- African American
- Pacific Islander

- American Indian
- White Non-Hispanic

- Asian
- Hispanic
- Other _____

• **Religious Preference:** _____

V. SCHOOL INFORMATION

Name: _____

Address: _____

Phone: _____

Teacher's Name: _____

School Nurse: _____

Special Attendant: _____

Grade/Placement: _____

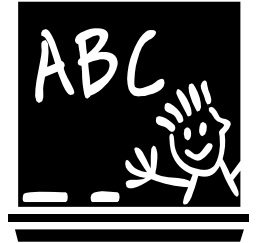
Type of class: _____

Special Services: _____

Transportation: _____

IEP Date: _____

Goals: _____



• **School Concerns**



VI. FAMILY HISTORY Unknown

Please complete the following table including your child's grandparents by checking the appropriate box.

	Father	Mother	Sib					Grand-mother	Grand-father	Grand-mother	Grand-father
Age											
Age at death and cause											
Health Status: Excellent, good, fair, poor											
Arthritis: Yes or No											
Cancer: Yes or No											
Diabetes: Yes or No											
Heart Condition: Yes or No											
Lung Disease: Yes or No											
Stroke: Yes or No											
Smoker: Yes or No											
Mental Illness: Yes or No											
Other:											

VII. MONTHLY WEIGHT CHART

DATE/YEAR	WEIGHT IN LBS.	CHANGE +/-	DATE/ YEAR	WEIGHT IN LBS.	CHANGE +/-
JAN.			JULY		
FEB.			AUG.		
MAR.			SEPT.		
APRIL			OCT.		
MAY			NOV.		
JUNE			DEC.		



VIII. GATE 1 ORIGINAL NORMAL STATUS

Date Completed: _____

The Child Profile is your portable medical record. Record your child's original Gate 1 normal status here. Then you will have a record of changes in your child's status for one year. We have included a pain rating scale at the bottom of this sheet to help you communicate your child's pain to his/her physician. If your child has no special needs in a certain area put not applicable in the normal status or normal.

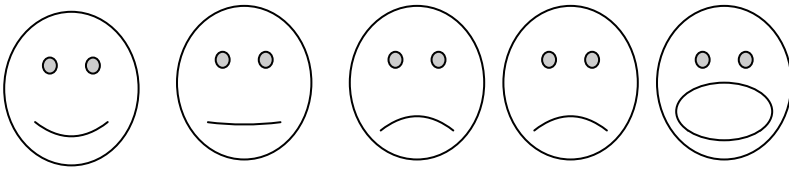
Areas to Check:

My Child's Normal Status Is:

Skin Temperature	
Skin Color	
Rash	
Drainage	
Heart rate	
Nose	
Eyes	
Ears	
Fontanel	
Seizure Activity	
Verbal Skills	
Activity Level	
Breathing	
Vent Dependent/ Tracheostomy/C-Pap	
Oxygen	
Motor Skills	
Upper Body Extremities	
Lower Body Extremities	
Stool	
Urine	
Feeding behaviors/appetite/source	
Ostomy Sites	
Behavior/Attitude	
Sleeping Pattern	
Temperature	
Blood Sugars	
Other	

1 2 3 4 5





You are your child's best advocate. Keep good data!

Pain Rating Scale

IX.

IMMUNIZATION AND ALLERGY RECORD LOG



best)

Child's Name: _____

Physician's Signature: _____

Immunization	Date	Date	Date	Date	Date	Reaction if any	Physician
Diphtheria-Tetanus (DT)							
Diphtheria-Pertussis-Tetanus (DPT)							
Tetanus							
Polio (OPVIPV)							
Measles-Mumps- Rubella (MMR)							
Measles-Rubeola (MR)							
Mumps							
Rubella (3Day Measles)							
Haemophilus Influenzae (HIB)							
Hepatitis A							
Hepatitis B							
Varicella (Chicken Pox)							
Rotavirus							
Pneumovoccal (Pneumovac)							
Pneumococcal Conjugate							
Influenzae (Flu Shot)							

• **Skin Test Log**

Test	Date	Result	Provider
Newborn Screen			
Tuberculosis (TB)			

