Name:
Date of Birth:

Portable Medical Summary

ABOUT ME

First Name:	Last Name:	Middle:	Sex:	Birthdate:	Age:	Medical Record Number (System):

[Attach/Insert Photo Here]

Things I like and things I am good at

Best way to talk and listen to me/How I ask for help when I'm ill

How I move and get around

How I do my daily activities (eating, dressing, toileting, bathing)

Helpful tips when working with me

ABOUT MY FAMILY

Primary Caregiver (or Self):	Relationship:	Phone:	Email:		
Street Address:	City:	State:	Zip:	County:	
Secondary Contact:	Relationship:	Phone:	Email:		
Street Address:	City:	State:	Zip:	County:	
Legal Decision Maker(s):	Emergency Contact Person (Relationship):	Phone:			

Preferred Communication/ Best times/days to contact:	
Transportation Means:	
Caregivers' Occupations:	
Patient's/Caregiver's learning preferences:	☐ Reading ☐ Spoken info/instruction ☐ Demonstration/shown how ☐ Listening to audio/tapes ☐ Looking at pics/video

MY FAMILY, CAREGIVERS, SIBLINGS, OTHERS

First and last names	Year of Birth	Relationship to patient	Where resides (full time, scheduled or different home)

INSURANCE INFORMATION

Primary Insurance:		ID Number:		Group #:	

Name:
Date of Birth:

Policy Holder:		Employer:		Policy Holder DOB:	
Secondary Insurance:		ID Number:		Group #:	
Policy Holder:		Employer:		Policy Holder DOB:	
Medicaid Waiver:	Choose an item.	☐ Active ☐ Targeted ☐ Wait List ☐ Applied		Application Date:	
Case Management Co:		Case Manager:		Contact Info:	

EDUCATIONAL SERVICES

Current Services

Type:	☐ First Steps ☐ Preschool ☐ Homeschool ☐ K-12: ☐ Work ☐ Day Program ☐ Other:		
School Name:		School District:	
Exit year:		Eligibility Categories/ Setting:	
Services:	☐ Individualized Education Plan (IEP) ☐ Behavioral Intervention Plan (BIP) ☐ 504 Plan ☐ Individual Health Plan (IHP)	☐ Speech Therapy ☐ Developmental Therapy ☐ Occupational Therapy ☐ Physical Therapy	☐ Assistive Technology (inc. AAC) ☐ Vocational Rehab: ☐ Other: ☐ Other:
Work:	Setting:	☐ Full time ☐ Part time ☐ with accommodations	
Primary School/Work Contact:	Name:	☐ Classroom Teacher ☐ Teacher of Record ☐ Nurse ☐ Other:	
	Phone:	Fax:	Email:
School/Work History:			

Neuropsychology and Psychoeducational Testing

Date of Testing:	Name of Provider/Clinic:
(Testing Results)	

CHILDCARE

Childcare type:	☐ Family ☐ Paid In-home ☐ Center-based ☐ Other:		Attendance:	☐ Full-time ☐ Part-time
Primary Contact:	Name:	☐ Caregiver ☐ Facility ☐ Other:		
	Phone:	Email:		

Name:
Date of Birth:

CONDITIONS and MEDICAL HISTORY

Diagnosis		Diagnosis	
Birth/Genetic:		Cardiovascular:	
Dental:		Endocrine:	
Ears, Nose, & Throat:		Gastrointestinal:	
Genitourinary:		Hematology:	
Infectious Disease:		Musculoskeletal:	
Neurologic:		Ophthalmology:	
Psychological:		Renal:	
Respiratory:		Skin:	
Neurodevelopmental:		Behavioral:	

HEALTH CARE TEAM

Primary Care Provider:		Phone:		Fax:			
Care Coordinator:		Phone:		Last Visit:		Next Visit:	
Street Address:		City:		State:		Zip:	
Preferred Hospital:		Phone:		Fax:			

Care Team	Name/Type/Location	Last Visit	Follow-up Visit	Contact Info
Specialist 1:				
Specialist 2:				
Specialist 3:				
Specialist 4:				
Specialist 5:				
Specialist 6:				
Psych / Behavior Therapy:				
Dentist:				
Vision:				
Hearing:				
Therapy (OT/PT/SLP):				

SERVICES

Home & Community-Based or Waiver Services

Home Care Provider:		Phone:	
Waiver Service Provider:		Phone:	
Community Agency Provider:		Phone:	

Medical Equipment & Services Suppliers

Medical Equipment & Supplies:			
Vendor/service/contact:		Phone:	
Vendor/service/contact:		Phone:	

Name:
Date of Birth:

VITAL SIGNS							
Date:		Weight:		Height:		BMI:	
BP:		Temp:		HR:		HC:	
O2 Sat:		RR:		Notes:			

EMERGENCY PLAN:

ALL MEDICATIONS – Including Over the Counter & Alternative

	Medication name (brand & generic names)	Form	Dose	Times	Comments: Purpose, special instructions; all oral unless otherwise noted	Prescriber
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

***Please always verify current medications and dosing before treating.**
This medication list was last verified on the SPOC reassessment date listed above, unless otherwise stated below.

Special Instructions:					
Medication Allergies/ Contraindications:		Medication History:			
Preferred Pharmacy:		Phone:		Fax:	

Other Treatments

Diet:	
Other:	
Safety Needs/ Risks:	

Immunizations (per CHIRP {date})

Vaccination record

FAMILY HISTORY

Condition	Who?	Condition	Who?	Condition	Who?
Heart Disease:		Hypertension:		Diabetes:	
Mental Health:		Cancer Type:		Genetic:	
Neurodevelopmental:		Lipids:		Other:	

HOSPITALIZATIONS

SURGERIES

Name:
Date of Birth:

PROCEDURES
LABS
Notes/Other