CHILDREN'S Rehabilitation Service

USA HEALTH

Shared Plan of Care

My Name Is:

My Date of Birth Is:

My Diagnosis Is:

Get to Know Me:

My nickname is: _____

My favorites include:

Friends: _____

Pets/Animals: _____

Toys: _____

Games/Hobbies: _____

Foods: _____

I go to school at: _____

I can do all these things by myself:

_____

_____

I need help with:

_____

_____

I express pain by:

_____

_____

Related Services/Therapies

Equipment	Service Date	Service By

Nutritional Needs:

I See These Providers/Specialists:	Last Appt. & Outcome	Next Appt.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ER Visits/Hospital Stays/ER Visits:	Date & Outcome
_____	_____
_____	_____
_____	_____
_____	_____

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Shared Plan of Care

My Name Is: **My Date of Birth Is:**	**Allergies:**	
Prescriptions/Reason for Treatment:	**Prescriber:**	**End Date:**

If the patient is between the ages of 14-21 please answer the following questions on transition:

Is the patient interested in working after high school graduation?	**Yes**	**No**
Is the patient interested in continuing their education after high school graduation?	**Yes**	**No**
Patient is currently utilizing Vocational Rehabilitation Services, or a referral was made?	**Yes**	**No**
Is the patient receiving Medicaid Waiver Services?	**Yes**	**No**
If yes, what Medicaid Waiver Services?		
If no, would you like information about the different Medicaid Waiver Services?	**Yes**	**No**

My Goals

Name: _____ **Date of Birth:** _____

Below is a list of the things that I as the client/parent want to accomplish. I am initialing by each goal to indicate my involvement in writing the goals and developing the action steps.

GOAL	**NEED/CONCERN**	**ACTION**	**OUTCOME/DATE**
	NEED/CONCERN	**ACTION**	**OUTCOME/DATE**
	NEED/CONCERN	**ACTION**	**OUTCOME/DATE**

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