Office for Children with Special Health Care Needs
VCTC Documentation Form

Date of Conference: ________________ Start Time: _________ End Time: _________

Patient Name: ______________________________ Age: ________ DOB: ________________

Parent: ____ ☐ present

Youth: ____ ☐ present

PCP: ____ ☐ present

Present for conference:

Name

	Diagnosis	Date		Diagnosis	Date
Birth/ genetic			Cardiovascular		
Dental			Endocrine		
ENT			Gastrointestinal		
Genitourinary			Hematologic		
Infectious Disease			Musculoskeletal		
Neurologic			Ophthalmologic		
Psychiatric			Renal		
Respiratory			Skin		
Neurodevelopmental			Behavioral		

Medication Name	Form/Route	Dose	Time of Day	Reason

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Questions addressed during conference:

Other issues addressed during conference:

Needs:

- ☐ Surgery
- ☐ Information for school
- ☐ F2F referral
- ☐ Labs/Studies
- ☐ Emergency Forms
- ☐ Therapy
- ☐ Care Coordination
- ☐ Home Health
- ☐ DME

Follow up:

Provider	Reason	Date

Summarize Goals for team:

Goals	Action/Strategies	Accountable Person	Timeline
Family (what matters)			
Patient			
Clinical			

Coordinator signature: ______________________________________ Date: ____________

Send copy of conference documentation to parents and all providers listed on form.