Office for Children with Special Health Care Needs
Virtual Care Team Conference (VCTC)
Shared Plan of Care

Date of Conference: _____ Start Time: _____ End Time: _____

A DEMOGRAPHICS

Patient Name: _____ **Age**: _____ **DOB**: _____ ☐ present

Parent/Guardian: _____ ☐ present

PCP: _____ ☐ present

B CARE TEAM

Name: (i.e., specialists, PT, school)	**Role:**	**Location:**	**Phone Number:**	**Follow-up visit date**
Add if present				

C GETTING TO KNOW YOU

What do you see as your child's strength?

As a parent/guardian, what is the most important goal for your child?

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D Questions or Concerns

Parent:

Providers:

E DIAGNOSIS

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

F MEDICATIONS

Medication Name	Prescriber/Provider	Form/Route Dose	Time of Day	Reason

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G NEEDS

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

H REFERRALS

Name	Address	Number	Specialty

I ACTION PLANS

	Action/Strategies	Accountable Person	Timeline
Care Coordinator			
Family			

J PHARMACY

Pharmacy Name	Location	Phone Number

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K	SCHOOL

School Name and Address	Contact Person	Number

Does the child have IEP? ☐ yes ☐ no Does the child have 504? ☐ yes ☐ no

L	NEXT VISIT

Date	Doctor and Location	Number

DO NOT WRITE BELOW THIS LINE

VCTC Coordinator: _____ Date: _____

Date sent copy of VCTC Shared Plan of Care to parents and all providers listed on form:_____