Transition Summary

Name ____________________________ DOB ___________________ SS# _________________

Address ____

Phone ____

Emergency Contact __________________ Relationship ______________ Phone ______________

Guardian/Medical Surrogate ______________ Relationship ___________ Phone ______________

Communication needs ____

Assistive technology ____

Primary Insurance ____

Secondary Insurance ____

Health Care Insurance Plans ____
□ if none, consider referral to social work

Physician	Address	Phone number/Fax
PMD:		
Future PMD:		

□ if none, refer to ICAAP physician network

Diagnosis	Managing Provider	Address	Phone
1.			
2.			
3.			
4.			
5.			

□ plans for sub-specialty transition?

Current Medications	Current Medications

Allergies: ____

Please attach recent labs, imaging and other studies.

Please attach most recent history and physical exam and immunization history.

Medical Equipment	Medical Supplies	Provider	Contact Info
1.			
2.			
3.			
4.			

Past Hospitalizations/Surgeries

Date	Hospital Name	Reason	Physician

□ Hospital records included

Functional Capabilities
Upper Extremities
Lower Extremities
Speech/Language
Cognitive/Problem Solving

Services Receiving	Address
1.	
2.	
3.	

Brief medical history/prognosis/disease course: ____

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School address _______________________________________ Phone __________________________

Hobbies ____

After high school plans ____
□ if none, provide informational hand-out or refer to social work.