Special Health Care Plan

This form is to be completed by the Member's parent/guardian(s) and/or advocate(s).

The Special Health Care Plan provides information to health care providers on how to best accommodate the special health concerns and needs of this member. *It also provides information on how to best approach the member when providing routine care.*

Member name: _____ Date: _____

Member ID: _____

Description of Health Condition(s)

Describe each condition:

_____

_____

_____

Team Member Names and Titles (include parents)

Parent/Guardian: _____

Health Care Provider (MD, NP): _____

California Children's Services (CCS) Provider: _____

Case Manager (Tri-County Regional Center - TCRC): _____

Case Manager (CM or ECM): _____

Team Member; Other Support Programs (name, program, contact information, frequency)

☐Physical Therapist (PT): _____

☐Occupational Therapist (OT): _____

☐Speech & Language Therapist: _____

☐Social Worker: _____

☐Mental Health Professional (CenCal Health – therapist, ABA provider, psychiatrist):

_____

☐Mental Health Professional (County): _____

☐Other (Respite workers, Home Health Aide, CCS Provider etc.):

_____

Medical Information

Current List of Medications:

_____

Allergies ☐ Yes ☐ No

If yes, please list:

_____

_____

Safety

Strategies to support the Member's needs and safety issues while receiving care. Please outline steps/resources (such as having female staff only work with the member) that should be taken by health care staff when dealing with the member during health visits (i.e. dental cleanings, dental work, annual physical, immunization shots, bloodwork etc.):

_____

_____

_____

Behavior Concerns

Please list specific changes in behavior that arise as a result of the health-related condition/concerns:

_____

_____

_____

_____

Emergencies

Emergency contact: _____Telephone: _____

Health Care Provider: _____ Telephone: _____

Emergency Form Completed ☐ Yes ☐ No

Follow-up, Updates, and Revisions

This Special Health Care Plan is to be updated/revised whenever the member's health status changes or at least every ____ months as a result of the collective input from member's care team.

Due date for revision and team meeting: _____.

Attach additional information if needed. Include unusual episodes that might arise while the child is receiving care, how the situation should be handled, and special emergency or medical procedures that may be required.