Date Completed: _____ Date of Last Revision: _____

Resuscitation Status:
☐ Discussed ☐ Not discussed
☐ Report attached

Portable Medical Summary

Name: _____	Birth date: _____ ☐ Male ☐ Female	Home Phone: _____
Address: _____	E-mail: _____	Mobile Phone: _____ Work Phone: _____
Guardian/Surrogate: _____	Relationship: _____	Home Phone: _____ Mobile Phone: _____
Emergency Contact: _____	Relationship: _____	Home Phone: _____ Mobile Phone: _____

Health Care Providers

Pediatric		**Adult**	
Name: _____ Specialty: Primary Care Provider	Phone: _____ Fax: _____	Name: _____ Specialty: Primary Care Provider	Phone: _____ Fax: _____
Name: _____ Specialty: _____	Phone: _____ Fax: _____	Name: _____ Specialty: _____	Phone: _____ Fax: _____
Name: _____ Specialty: _____	Phone: _____ Fax: _____	Name: _____ Specialty: _____	Phone: _____ Fax: _____
Name: _____ Specialty: _____	Phone: _____ Fax: _____	Name: _____ Specialty: _____	Phone: _____ Fax: _____
Name: _____ Specialty: _____	Phone: _____ Fax: _____	Name: _____ Specialty: _____	Phone: _____ Fax: _____

Allergies/Sensitivities	**Reaction**	**Date**	**Allergies/Sensitivities**	**Reaction**	**Date**
1. _____			5. _____		
2. _____			6. _____		
3. _____			7. _____		
4. _____			8. _____		

Medicines, Foods, & Procedures To Be Avoided	**Reaction**	**Date**
1. _____		
2. _____		
3. _____		

Diagnosis(es)		**Problem List**
Height:	**Weight:**	
Baseline vitals:		**Mobility/Transfer Status:**
Baseline Neurological Status:		☐ **Medication Record Attached** ☐ **Immunization Record Attached**

Patient Name: _____ DOB: _____

Baseline Abnormal Physical Findings and Labs	

Pertinent Surgeries/Procedures	Date	Pertinent Surgeries/Procedures	Date

Recent or Important Hospitalizations: Diagnosis(es) & Treatment Summary	Hospital	Date

Additional Notes

Transition Goals	Plan
1.	
2.	
3.	

Patient Signature:	Date:
Parent/Guardian Signature:	Date
Provider Signature:	Date:

Patient Name: _____ DOB: _____

Expanded Information

Therapies/Other Services (therapies, vocational, educational, home-based services, care coordination)			
Type	Frequency	Provider	Phone

Maintenance Routines (i.e. bowel/bladder, respiratory, nutrition, etc.)	
1.	4.
2.	5.
3.	6.

Equipment/Supplies				
☐ Trach tube type: Size:	☐ Nebulizer	☐ G-tube type cm	☐ Wheelchair	☐ Orthotics/ Prosthetics
☐ Vent type	☐ Pulse ox	☐ Feeding pump	☐ Crutches	☐ communication device
☐ O2 stationary/portable	☐ Suction machine/supplies	☐ Glucose monitor	☐ Walker	☐ Assistive devices for ADLs
☐ Apnea monitor	☐ BP monitor	☐ Cardiac monitor	☐ Hearing aid	☐ Other
Instructions and Contact Information for Supply Orders:				

Additional Information:

Patient Signature:	Date:
Parent/Guardian Signature:	Date
Provider Signature:	Date:

Patient Name: _____ DOB: _____

Medications/Supplements	Dosage	Time	Purpose	Possible Side Effects

Patient Signature:	Date:
Parent/Guardian Signature:	Date
Provider Signature:	Date:

Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials: