



**Medical Home Initiative Southwest CT
For Children & Youth with Special Health Care Needs**

1351 Washington Blvd. • Stamford, CT 06904 • Tel: 203-276-7552 Toll Free: 866-239-3907 Fax: 203-276-2134

Name of Practice: _____
Address: _____
Telephone #: _____ Fax #: _____
Name of My Doctor: _____

Picture

Portable Health Record

Patient Name: _____ Date of Birth: ____ / ____ / ____
Parent name: _____
Address: _____
Phone number: _____ Account No: _____ Insurance: _____
Complexity index grade: _____ Next visit due on: _____
Primary Diagnosis: 1. _____
Additional Diagnosis: 2. _____
3. _____
Problems: 1. _____
2. _____
3. _____

REMINDER: Bring this document to all appointments and for any emergency visits.





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Important Baseline Data (Labs, X-Ray, EKG, Neurologic findings):

1. _____
2. _____
3. _____

Allergies (medications/foods to be avoided)

Why?

Allergies (medications/foods to be avoided)	Why?

Medication

Purpose

Dose

Medication	Purpose	Dose





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Specialist Services:

Specialty	Name	Phone	Fax	Next Visit
<input type="checkbox"/> Pulmonologist				
<input type="checkbox"/> Cardiologist				
<input type="checkbox"/> Gastroenterologist				
<input type="checkbox"/> Ophthalmologist				
<input type="checkbox"/> Surgeon				
<input type="checkbox"/> Dentist				
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				

Services provided:

1. School _____
2. Social Services _____
3. Support Groups _____
4. Extended Care _____
5. Respite _____
6. Camps _____





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Support Services:

<u>Service</u>	<u>Provider</u>	<u>Phone</u>	<u>Fax</u>	<u>Frequency</u>	<u>Next Visit</u>
<input type="checkbox"/> PT					
<input type="checkbox"/> OT					
<input type="checkbox"/> Speech					
<input type="checkbox"/> Hearing					
<input type="checkbox"/> Spl Ed Teacher					
<input type="checkbox"/> Pharmacy					
<input type="checkbox"/> Home Care					
<input type="checkbox"/> Equipment					
<input type="checkbox"/> Nutritionist					
<input type="checkbox"/> Other					
<input type="checkbox"/> Other					

Family Strengths: 1. _____
2. _____
3. _____

Immunization Record: (see attached)

Additional Information:

