|  |  |  |
| --- | --- | --- |
| **Shared Care Plan**  for Children and Youth with Special Health Needs | | |
| **Child/youth name:** | | **Necessary releases obtained:**  Yes  No |
| **Child/youth likes to be called:** | | **Team meeting date:** |
| **Date of birth:** | | **Meeting location:** |
| **Parent(s):** | | **Referred by:** |
| **Parent phone #:** | | **Other:** |
| **Primary care provider:** | **Interpreter (if applicable):** |
| **Gender identity:**  M  F  Other, please specify: | |
| **Pronouns:** She/HerHe/HimOther, please specify: | |
| **Child/Family Strengths and Assets** | | |
|  | | |
| **Child/Family Language and Culture** | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Child/Family Concerns and Goals** | | | |
| For today: | | | |
|  | | | |
| For the longer term: | | | |
|  | | | |
| **Brief Medical Summary** | | | |
| **Diagnosis:** | | | |
| **Medications:** | | | |
| **Current Interventions:** | | **Tried Interventions:** | |
| **Health Care Providers:** | | | |
| **Other Important Medical Information (Allergies/Alerts):** | | | |
| **Preferred Hospital:** | | **Preferred Pharmacy:** | |
| **Brief Summary of Involvement with Education/Community-Based Services** | | | |
|  | | | |
| **Team Members Contact List** | *Note: Initial next to name to note attendance at meeting. Add rows as needed.* | | |
| **Name** | **Role/Responsibility** | | **Best way to contact** |
|  | Family member | |  |
|  | Primary care provider | |  |
|  | Education | |  |
|  | Mental/behavioral health | |  |
|  | Public health | |  |
|  | Health plan/insurance | |  |
|  | Interpreter | |  |
|  |  | |  |
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| **Action Plan** | *Note: Add rows as needed.* | | |
| * The first goal of the team should be one that is identified by the family as a priority. * If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare. | | | |
| **Shared goal:** | **Who?** | **Is doing what?** | **By when?** |
|  | This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| **Date identified:** | **Notes:** | | |
| **Date resolved:** |

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| --- | --- | --- | --- |
| **Action Plan** | *Note: Add rows as needed.* | | |
| * The first goal of the team should be one that is identified by the family as a priority. * If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare. | | | |
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| This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| **Date identified:** | **Notes:** | | |
| **Date resolved:** |

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| **Action Plan** | *Note: Add rows as needed.* | | |
| * The first goal of the team should be one that is identified by the family as a priority. * If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare. | | | |
| **Shared goal:** | **Who?** | **Is doing what?** | **By when?** |
|  | This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| This person | Will take this action | By this date  **Date completed:** |
| **Date identified:** | **Notes:** | | |
| **Date resolved:** |

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