Palmetto Pediatric
& Adolescent Clinic, P.A.

My Care Plan

Please call me: _____
I speak _____
I am Non-verbal Deaf Blind

Name: _____
DOB __/__/____ Chart #_____
SSN # _____
INS: _____ ID# _____
2° Ins_____ ID# _____
Requires Pre-cert/auth □ Yes □ No
Medicaid # _____

Date Completed: __/__/__

Family Members
Mom _____Siblings_____
Dad _____ _____
_____ _____
_____ _____

Patient Address/ Phone

_____

_____

email

_____

Emergency Contact/Telephone:

Medical Home Address/Phone

PCP _____

Care Coordinator Kim Conant 865-6180
Fax# 462-0365

ICD-9	Diagnosis

Allergies: _____
_____

Pharmacy: _____
Tel No: _____

DME Supplier: _____
Tel No: _____ **Fax #:**_____
I use: _____ _____
_____ _____
_____ _____

ation/Special Formula	Dose	Time	Route	Ordered by/date	D/C'd

- BabyNet Contact: _____ Tel _____Fax_____
- CRS Contact: _____ Tel _____Fax_____
- Family Connections _____ Tel _____Fax_____
- DDSN Contact _____ Tel _____Fax_____
- School/daycare _____ Tel _____Fax_____

District: _____ School emergency plan attached if applicable
Contact Person/School Nurse _____

Lead Service Coordinator _____ **Agency** _____

Provider MD's/Therapists	Service	Freq	Address	Telephone	Fax
	PCP	Wv&prn			
	dentist				
	Allergy				
	Audiology				
	Cardiology				
	Craniofacial				
	Dermatology				
	Dev peds				
	Endocrine				
	ENT				
	Gastro				
	Genetics				
	Inf disease				
	nephrology				
	Neurosurg				
	Neurology				
	Nutritionist				
	Onc-Hem				
	Ophthal				
	Ortho				
	Plastic Surg				
	Psychiatry				
	Psychology				
	Pulmonology				
	Sleep med				
	Spasticity				
	Surgery				
	Urology				
	EI				
	OT				
	PT				
	SLP				
	O & M				
	Vision				

Needs and Plan of Care:

Date to be reviewed: No Later than _____

Staff Signature/Title: _____Date:__/__/__

I give my permission to share the information on the care plan with each of my child's provider's except:

_____