



Intermountain Sandy Clinic
9500 South 1300 East
Sandy, Utah 84094

Dear Parents,

The pediatric team at Intermountain Sandy Clinic has implemented a program called “**Medical Home**”. This program is designed to improve care for children with specialized needs.

To help us improve the care that is delivered to your child, we ask you to fill out the attached “**Portable Medical Health History**” and return it to our pediatric nurse care manager, Kathy Heffron.

We will take the information you supply and combine it with the notes from the medical record to complete an accurate report in your child’s Intermountain Electronic Medical Record. You will be given a copy for your records to use for future reference.

Your pediatrician regards this report as another valuable tool for serving the needs of your child. It is our hope that you won’t have to repeat the medical history every time you see new people.

Since information changes as your child grows and develops. We ask that you contact us so we can update changes in medication, therapies, specialists etc.

Thank you so much for allowing us to work with you and your child. If you have any question or concerns, please call us at 801-501-2181.

Sincerely,

Intermountain Sandy Clinic
Department of Pediatrics

Child's Name: _____ Gender: M F Date of Birth: _____
Language Spoken: English / Other: _____ Alternative Communication: No/Yes _____

FAMILY RELATIONSHIPS:

Parent 1: _____ Mother/Father : Biological/Adoptive/Foster/Step Other: _____ Does child live with? Y N
Phone: _____ Cell Phone: _____ Legal Guardian: Y N Status: Married / Separated / Divorced
Address: _____ Is this your mailing address? Y N

Parent 2: _____ Mother/Father : Biological/Adoptive/Foster/Step Other: _____ Does child live with? Y N
Phone: _____ Cell Phone: _____ Legal Guardian: Y N Status: Married / Separated / Divorced
Address: (If different from above) _____ Is this your mailing address? Y N

LEGAL/INSURANCE:

Legal Decision Maker: Parent / Guardian / Self Name: _____ Phone: Home _____ Cell _____ Work _____
Legal Health Surrogate: (If applicable) Name: _____ Phone: Home _____ Cell _____ Work _____

Health Insurance(s):
Primary: _____ Policy #: _____ Phone: _____ Case Manager: Y N
Secondary: _____ Policy #: _____ Phone: _____ Case Manager: Y N

MEDICAL/HEALTH:

Mental/Cognitive Ability Concerns: _____

Unique Medical Needs: _____

DNR (do not resuscitate) Status: ___ Yes, resuscitate ___ No, do not resuscitate (MD order) ___ Modified resuscitation (MD order)
Advanced Directives/Living Will: Yes/No

Height: _____ Weight: _____
Allergies: (Include reactions)
1. _____ 3. _____
2. _____ 4. _____

Primary Care Physician: _____ Clinic: _____ Phone: _____

Main Diagnosis: _____
Other Problems/Diagnoses: 1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Recent Hospital Admissions: (Please give dates and reasons)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Specialists/Therapists: (Please give name and phone number)

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Dentist: _____ Clinic: _____ Phone: _____

Immunization Status: Current? Yes As of date _____ No Needs _____

Medications: (Long-term, give dose, date started and ended)

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

As Needed Medications: _____

Pharmacy: _____ Location: _____ Phone: _____

Home Health Nursing:

Agency: _____ Phone: _____

Services Provided: Private Duty Nursing, # hours/week: _____ Skilled Nursing Visits IV Therapy, line type: _____

Respite Care, # hours/month: _____ If not same agency, list name/phone: _____

Medical Equipment:

Agency: _____

Phone: _____

- Oxygen, _____ liter flow/minute
- Apnea monitor
- Pulse oximeter
- Nebulizer
- Suction Machine
- Trach, tube type/size: _____ Suction depth: _____ Cuff: Y N
- Vent/BiPAP/CPAP, type/settings: _____
- Other: _____
- Feeding pump/supplies, type: _____
- IV medication pump
- Central line supplies, type: _____
- Wheelchair(s) (Power / Manual)
- Hospital bed
- Custom bracing/prosthetics, type: _____
- Specialized car seat

NUTRITION:

Diet: Regular / Formula, type: _____ Feeding method: By mouth / NG / NJ / G-Tube If tube, list type/size: _____

Feeding issues/plan: (reflux, vomiting, oral aversion, malabsorption, underweight, overweight) Additional information: _____

FUNCTIONAL/DEVELOPMENT:

Developmental delay Estimated developmental age: _____

Developmental Services/Rehab Agency: _____ Phone: _____

Therapies Provided: Physical, how often? _____ Occupational, how often? _____ Speech, how often? _____

Location of Services: Home Outpatient School

Developmental Programs:

Neonatal Follow-Up Infant Development Program Early Intervention Program, Agency: _____

EDUCATION:

School: _____ Phone: _____ Grade level: _____ Special Education: Y N

Educational Supports: Individual Education Plan (IEP) 504 Plan

School Counselor/Psychologist: _____ Phone: _____

Teacher: _____ Phone: _____

MENTAL HEALTH:

Psychiatrist (MD): _____	Location/Clinic: _____	Phone: _____
Psychologist: _____	Location/Clinic: _____	Phone: _____
Counselor/Social Worker: _____	Location/Clinic: _____	Phone: _____

Spiritual Contact: _____ Phone: _____

RESOURCES:

Please mark the services that your child/family receives or uses: (For information about any service, please place a “?” by the “”)

- Medicaid, Caseworker: _____ Phone: _____
- Division of Services for People with Disabilities (DSPD), Caseworker: _____ Phone: _____
- Social Security Income (SSI)
- Waiver Program: Travis C./Tech Depend Brain Injury DDMR Physical Disability
- WIC Nutrition Program
- Work Force Services: Food Stamps Child Care Housing Assistance
- Recreation Services: _____
- Support Groups: _____
- Transition to Adult Services: Special Needs Wills/Estate Planning/Trusts Guardianship Vocational Rehab Adult Medical Care

- Emergency Medical Services for Children (EMSC)/CSHCN Health Information Sheet

- Children with Special Health Care Needs, Clinic: _____
- Utah Parent Center
- National Alliance on Mental Illness (NAMI)
- Allies with Families
- Jordan Family Education Center

- Foundations: Make-a-Wish Easter Seals March of Dimes

- Others:

FAMILY NEEDS:

Major Family Concerns:

LAST REVISION DATE: