Packaging Wisdom

A Family Centered Care Coordination Notebook

Presented by:

Wyoming Department of Health

Children’s Special Health

Maternal and Family Health

Feel free to make copies of any pages in this book!
ACKNOWLEDGEMENTS

Special thanks to the following people whose help made Packaging Wisdom possible:

**************************
The many families of children with special healthcare needs in Wyoming for sharing your experiences to determine what should be in this book.
**************************

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This notebook has been thoughtfully put together for your convenience of use. Below are some suggestions.

Follow these steps to set up and/or make changes to your child’s notebook:

Step 1: Gather information
Gather any health information about your child; this may include reports from recent doctor’s visits, recent summary of a hospital stay, this year’s school plan (IEP), test results, or informational pamphlets.

Step 2: Look through the pages of the notebook
Which of these pages could help you keep track of information about your child’s health or care? Choose the pages you like. Print copies of any that you think you will use. Packaging Wisdom pages are available through the internet at http://wdh.state.wy.us/familyhealth/csh/index.html, choose Packaging Wisdom.

Step 3: Decide which information about your child is most important to keep in the notebook
What information do you look up often? What information do people caring for your child need?

Step 4: Put the notebook together
Everyone has a different way of organizing information. The goal of this notebook is to make finding the information easier. We have provided the “tools”, now it is up to you to design the notebook in the most efficient way, thus allowing easier access to your child’s health information and care coordination.

YOU ARE THE EXPERT. YOU KNOW YOUR CHILD BETTER THAN ANYONE ELSE!
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Introduction:

What is Packaging Wisdom Notebook?

Packaging Wisdom is an organizational tool for families who have children with special healthcare needs and/or disabilities. This notebook has been designed for families living in Wyoming.

How can Packaging Wisdom help you?

In caring for your child with special healthcare needs and/or disabilities, you may get information and paperwork from many sources. Packaging Wisdom helps organize this information in one central location. This notebook will make it easier for you to find and share information with others who are a part of your child’s care coordination.

Use Packaging Wisdom to:

- Track changes in your child’s medications and/or treatments
- Contact information for healthcare providers and community organizations
- Prepare for appointments
- File information about your child’s health history
- Share new information with your child’s primary care physician, public health nurse, school nurse, daycare staff, and others who provide care for your child
- Training for any person(s) who will be caring for your child
- Transitional planning
- Family and child history in case of emergency

Helpful hints for using Packaging Wisdom

- Store Packaging Wisdom in a safe, easy to find location. This will help you and anyone who needs information in the event you are not there
- Add new information to the notebook whenever there is a change in your child’s condition, treatment, medication, provider, etc.
- We recommend taking Packaging Wisdom with you to appointments and/or hospital visits, this way any information will be ready and available

We hope this notebook will provide a sense of ease for you in maintaining information about your child.
Child’s Personal Information

First Name: _______________ Middle: _______ Last Name: _______________

Nickname: _______________ Date of Birth: _______/_____/______ Sex: M F

Street Address: _______________________________________________________

Mailing Address (If different than above): _______________________________________

City: __________ State: ______ Zip Code: ______

Phone: (____) _______

Color of Eyes: _______ Color of Hair: _______ Child’s Race: _______

Primary Disability: _____________________________________________________________

Other disabilities: ___________________________________________________________

Primary Language: _____________________________________________________________

Primary Means of Communication: ________________________________________________

Wheelchair? Y N Leg Braces? Y N Walks? Y N

Hearing? Excellent Good Fair Poor

Sight? Excellent Good Fair Poor Glasses? Y N

Handedness of Child? Right Left

Does your child understand directions? Y N

Safety Devices? Y N

List: __________________________________________________________

_______________________________________________________________

_______________________________________________________________

2.1
### Allergies
(i.e. food, animals, medications, environmental, etc.)  Y  N

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<tr>
<th>Date</th>
<th>To What?</th>
<th>What Happened?</th>
<th>Treatment</th>
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### Special Dietary Needs:  Y  N

List:

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Parents/Guardians

Mother:
First Name: __________________ Last Name: __________________
Home Phone:_______________ Work Phone:_______________
Education:_________________
Occupation:_________________
Employer Name:_____________ Marital Status:  M  S  D  W
Step-Father’s Name:_____________

Father:
First Name: __________________ Last Name: __________________
Home Phone:_______________ Work Phone:_______________
Education:_________________
Occupation:_________________
Employer Name:_____________ Marital Status:  M  S  D  W
Step-Mother’s Name:_____________

Primary Caregiver: (If different from Mother/Father)
First Name: __________________ Last Name: __________________
Home Phone:_______________ Work Phone:_______________
Education:_________________
Occupation:_________________
Employer Name:_____________ Marital Status:  M  S  D  W
**Who does your child reside with?** (i.e. brother, sister, grandparent, step-mom/dad, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Comments</th>
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**Notes:**

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2.4
Personality Traits: (i.e. tends to wander, bites, overly-friendly, etc.)

Likes:

Dislikes:

Fears: (i.e. storms, animals, dreams, etc.)

Favorites:
  Food: 
  Music/Songs: 
  Toys/Books: 
  Persons: 
  Animals: 

Hobbies:
Discipline is done by:  Mother  Father  Step-Mother  Step-Father  Caregiver

Method of Discipline: __________________________________________
______________________________________________________________

Child’s Reaction: ____________________________________________

Child’s Temper Tantrums: ______________________________________

Skills and Abilities:

Self-Help

Feeds Self, Using:

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>With Assistance:</th>
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<tbody>
<tr>
<td>Fork</td>
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<tr>
<td>Spoon</td>
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<tr>
<td>Knife</td>
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</tbody>
</table>

Bathes Self:    Y    N    With Assistance:_______________

Dresses Self:   Y    N    With Assistance:_______________

Undresses Self: Y    N    With Assistance:_______________

Toilet Trained: Y    N    With Assistance:_______________

Indicate the age of your child when he/she could:

Hold Head up ______ Follow Object with Eyes_____
Roll______     Play with Hands_____
Reach for Objects______ Crawl_____
Get into Sitting Position______ Sit Unsupported______
Pull up to Stand______ Stand Alone_____
Walk Alone______ Ate Table Foods______

Daycare Experience:

Date Started: ______________    How long there: ______________
Name of Provider: ______________
Type of Daycare: ______________
Positive Experiences: ____________________________
Negative Experiences: ______________________________

General Development
**Pregnancy and Birth History**

Problems with Pregnancy:  Y  N

Problems with Delivery:  Y  N

Length of Pregnancy: ________________

Health Problems during First Two Weeks of Child’s Life:

______________________________________

______________________________________

______________________________________

______________________________________

(Paste Birth Announcement Here)
Medical History

Diagnosed Medical Conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>When diagnosed?</th>
<th>Who Diagnosed?</th>
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</table>

**General Health:**  Good  Fair  Poor

Explain: ____________________________________________

**Last Vision Exam:** __________________________________________

**Last Dental Exam:** __________________________________________

**History of Seizures, Convulsions, and/or Staring Spells:**  Y  N

Explain: ____________________________________________

**Detail Hospitalizations, Serious Illnesses, Accidents, or Adverse Reaction to Immunizations:**

__________________________________________

__________________________________________

__________________________________________
## Family Medical History

### MOTHER’S FAMILY

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Health Conditions/Illnesses</th>
<th>Date Diagnosed</th>
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</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
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<tr>
<td>Grandmother</td>
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<tr>
<td>Grandfather</td>
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<tr>
<td>Aunt</td>
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<tr>
<td>Uncle</td>
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### FATHER’S FAMILY

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<tr>
<th>Relationship</th>
<th>Health Conditions/Illnesses</th>
<th>Date Diagnosed</th>
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<td>Mother</td>
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<td>Grandmother</td>
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<td>Grandfather</td>
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<td>Aunt</td>
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<td>Uncle</td>
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</table>

### CHILD’S SIBLINGS

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<tr>
<th>Relationship</th>
<th>Health Conditions/Illnesses</th>
<th>Date Diagnosed</th>
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<tbody>
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<td>Brother</td>
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<td>Sister</td>
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</table>
Family Medical History Cont.

**OTHER RELATIVES**

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<tr>
<th>Relationship</th>
<th>Health Conditions/Illnesses</th>
<th>Date Diagnosed</th>
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Notes:

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Emergency Contact Person(s)

None: _____

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Who else should be notified in the event of an emergency? (Clergy, Other relatives, friends, etc.)

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Name: ___________________________ Relationship: ___________________________
Home Phone: ______________________ Work Phone: ___________________________
Address: _________________________
City: ___________________ State: ____ Zip Code: __________

Preferred Religion?  Y  N  None
Church: ___________________________
Family’s religion and/or customs that may affect medical treatment of child:  Y  N
# Medications

<table>
<thead>
<tr>
<th>DATE STARTED</th>
<th>DATE STOPPED</th>
<th>MEDICATION</th>
<th>PRESCRIBED FOR</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>PRESCRIBED BY</th>
<th>ANY SIDE EFFECTS</th>
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2.12
Activities of Daily Living

Use this page to describe your child’s abilities to feed him/herself, bathe, get dressed, using the bathroom, combing hair, brushing teeth, etc.. Detail what your child can do by him/herself and any help or equipment your child uses for these activities. Describe any special routines your child has for bath time, getting dressed, etc...

Date: ________
# Care Schedule

<table>
<thead>
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<th>TIME</th>
<th>CARE</th>
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<td>Morning</td>
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## Care Schedule

<table>
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<td>Evening</td>
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Child’s Page

Use this page for your child’s words and thoughts about his/her life in the past, now, as well as in the future.

Date: ________

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2.16
Communication

Use this page to describe your child’s ability to communicate and to understand others. How does your child communicate? Include sign language words, gestures, equipment, or help your child uses to communicate and understand others. Include any special words your family and child use to describe things.

Date: __________

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Coping and Stress Tolerance

Use this page to describe how your child copes with stress. Stressful events might include new people, situations, hospital stay, or procedures such as having blood drawn. What upsets your child? What does your child do when he/she is upset? What happens when he/she has had “enough”? Describe your child’s way of asking for help and things to do or say to comfort your child.

Date: ________
Mobility

Use this page to describe your child’s ability to get around. Include what your child can do by him/herself and any help or equipment your child uses to get around. Describe any activity limits and any special routines your child has for transfers, pressure releases, positioning, etc...

Date: ________
Nutrition

Use this page to describe foods and any nutritional formulas your child takes, any food allergies or restrictions, and any special feeding techniques, precautions, or equipment used for feedings. Describe any special mealtime routines your family and child has.

Date: _________
Respiratory

Use this page to describe your child’s respiratory care needs, treatment needs, and any special techniques or precautions you use when giving care. Include any special routines your child has for respiratory care.

Date: ________
Rest and Sleep

Use this page to describe your child’s ability to get to sleep and to sleep through the night. Describe your child’s bedtime routine and any security or comfort objects your child uses.

Date: ________

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Social and Play

Use this page to describe your child’s ability to get along with others. Describe how your child shows affection, shares feelings, or plays with other children. Describe what works best to help your child get along or cooperate with others. Describe your child’s favorite things to do. Include any special family activities or customs that are important.

Date: _________

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2.23
Insurance Information

**Primary** Insurance Company:______________________________

Policy Number:__________________________________________

Contact Person:__________________________________________

Address:________________________________________________

Phone:_________________ Fax:___________________________

**Secondary** Insurance Company:____________________________

Policy Number:__________________________________________

Contact Person:__________________________________________

Address:________________________________________________

Phone:_________________ Fax:___________________________

**Medicaid** (Name on card):______________________________

ID Number:____________________________________________

DFS Caseworker:________________________________________

Office/Location of DFS Caseworker:________________________

Phone:_________________ Fax:___________________________

**Other**:______________________________________________

Policy Number:__________________________________________

Contact Person:__________________________________________

Address:________________________________________________

Phone:_________________ Fax:___________________________
Family Support Resources

Public Health Office: ______________________________________________________

Contact Person: ______________________________________________________

Address: ____________________________________________________________

Phone: ______________________ Fax: ____________________________

Department of Family Services: __________________________________________

Contact Person: ______________________________________________________

Address: ____________________________________________________________

Phone: ______________________ Fax: ____________________________

Counseling Services: _________________________________________________

Contact Person: ______________________________________________________

Address: ____________________________________________________________

Phone: ______________________ Fax: ____________________________

Other: _______________________________________________________________

Contact Person: ______________________________________________________

Address: ____________________________________________________________

Phone: ______________________ Fax: ____________________________

Other: _______________________________________________________________

Contact Person: ______________________________________________________

Address: ____________________________________________________________

Phone: ______________________ Fax: ____________________________
AUTHORIZATION TO ADMINISTER MEDICATION

Name of Individual receiving medication: ________________________________

I/We, ________________________________, guardian/parent of ____________________________, authorize ________________________________ to administer medications prescribed by his/her physician while in his/her care during our absence.

I/We understand that we will provide all dosage and administration information, and that we are responsible for understanding side effects of the medications and reporting these to the physician.

I/We understand that this authorization will be in effect one year from the date signed.

__________________________  Date: ________________
Guardian/Parent

__________________________  Date: ________________
Guardian/Parent
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PLEASE COMPLETE THE FOLLOWING:

Child’s Name: ____________________________

Date of Birth: ____________________________

Date of Last Tetanus Shot: ____________________________

Current Medications: ____________________________

Allergies to Medication: ____________________________

Chronic Medical Conditions: ____________________________

In the event of an emergency requiring medical treatment/aid due to illness or injury while in the care of ____________________________, I authorize medical or surgical care from a healthcare facility, physician, or dentist for my child. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the healthcare facility/physician/dentist may be taken. I further consent to transportation of the above-named child to the nearest or most appropriate medical facility.

Insurance Company that covers the above-named child is:

Name of Insurance Company: ____________________________

Address: ____________________________

Phone: ____________________________

Name of Policy Holder: ____________________________ Policy #: ____________________________

Medicaid Client: ____________________________ Medicaid #: ____________________________

ACS Phone #: ____________________________ (Attach copy of EqualityCare Card)

I authorize the hospital, and attending physician/dentist to submit claims to this company and to Medicaid, and hereby assign benefits directly to them.

Name: ____________________________ Date: ____________________________

Signature of Parent/Guardian

Witness: ____________________________ Date: ____________________________
Medical/Dental Healthcare Providers

Primary Care Provider: ________________________________
Date of First Visit: ________________________________
Office Nurse/Medical Assistant: ________________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Community Hospital: __________________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Dental Provider: _______________________________________
Date of First Visit: ____________________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Orthodontist: _________________________________________
Date of First Visit: ____________________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ____________________________
Specialty: ________________ Date of First Visit: __________
Office Nurse/Medical Assistant: _________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ____________________________
Specialty: ________________ Date of First Visit: __________
Office Nurse/Medical Assistant: _________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ____________________________
Specialty: ________________ Date of First Visit: __________
Office Nurse/Medical Assistant: _________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

There is more space to list Specialty Care Providers on the next page.
Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

Specialty Care Provider: ________________________________
Specialty: __________________ Date of First Visit: __________
Office Nurse/Medical Assistant: __________________________
Address: ____________________________________________
Phone: ___________ Fax: ___________ E-Mail: ___________

4.2
Therapists

Occupational Therapist (OT): ____________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________

Physical Therapist (PT): ____________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________

Speech-Language Pathologist: __________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________

Therapist:____________________________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________

Therapist:____________________________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________

Therapist:____________________________________________________________
Start Date:______________ End Date:______________
Agency/Hospital/Clinic:__________________________________________________
Address:____________________________________________________________
Phone:_________________ Fax:_________________ E-Mail:______________
Respite Care

Respite Care Provider: ________________________________
Start Date: ________________  End Date: ________________
Agency: ________________________________
Address: ________________________________
Phone: ________________  Fax: ________________  E-Mail: ________________

Respite Care Provider: ________________________________
Start Date: ________________  End Date: ________________
Agency: ________________________________
Address: ________________________________
Phone: ________________  Fax: ________________  E-Mail: ________________

Respite Care Provider: ________________________________
Start Date: ________________  End Date: ________________
Agency: ________________________________
Address: ________________________________
Phone: ________________  Fax: ________________  E-Mail: ________________
**Service Providers**
(Case Manager, Public Health Nurse, Service Coordinator, Respite, Children’s Waiver, ECT.)

Services: __________________________________________
Agency: __________________________________________
Contact Person: ___________________ Phone: ________________

Services: __________________________________________
Agency: __________________________________________
Contact Person: ___________________ Phone: ________________

Services: __________________________________________
Agency: __________________________________________
Contact Person: ___________________ Phone: ________________

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Card   Card
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Tape   Tape
Business Business
Card   Card
Here   Here
Early Intervention

Early intervention means early assistance where a special kind of partnership between parents and professionals gives every child the best possible start in life. The Department of Health’s Early Intervention and Education program is designed to help your child and your family receive the support you want and need. This program is designed to identify children at risk in the earliest stages, when the right help can make all the difference. This program is to support eligible children and families in enhancing a child’s potential growth and development from birth to age three (0-3).

Early Intervention Program Agency: ________________________________

Date Contacted: _______________ Date Started: _______________

Service Coordinator: ________________________________

Service Providers (therapists, nurse, etc...): ________________________________

Address: ________________________________

Phone: _______________ Fax: _______________ E-Mail: _______________

Hours of Operation: ________________________________
Child Care

Child Care Provider: ____________________________

Start Date: __________________________________

Address: ____________________________________

Phone: ___________ Fax: ___________ E-Mail: ___________

Important Information: ________________________________________________

Child Care Provider: ____________________________

Start Date: __________________________________

Address: ____________________________________

Phone: ___________ Fax: ___________ E-Mail: ___________

Important Information: ________________________________________________

Child Care Provider: ____________________________

Start Date: __________________________________

Address: ____________________________________

Phone: ___________ Fax: ___________ E-Mail: ___________

Important Information: ________________________________________________
**School Contacts**

School District:____________________________________________________
Address:_________________________________________________________
Phone: __________________ Fax: __________________ E-Mail:______________

Special Education Coordinator:________________________________________
Address:_________________________________________________________
Phone: __________________ Fax: __________________ E-Mail:______________

504 Accommodation Plan Coordinator (If different from above):
_______________________________________________________________
Address:_________________________________________________________
Phone: __________________ Fax: __________________ E-Mail:______________

District Nurse (Assigned to your child’s school):________________________
Address:_________________________________________________________
Phone: __________________ Fax: __________________ E-Mail:______________

************************************************************************

School:____________________________________________________________
Address:_________________________________________________________
Phone:________________________ Fax:________________________ E-Mail:________

Principal:_________________________________________________________
Phone:________________________ Fax:________________________ E-Mail:________

Classroom Teacher:_________________________________________________
Phone:________________________ Fax:________________________ E-Mail:________

Resource Instructor:_______________________________________________
Phone:________________________ Fax:________________________ E-Mail:________

Aide/Assistant/Intervener:___________________________________________
Phone:________________________ Fax:________________________ E-Mail:________

Special Education Director/Teacher(s):_______________________________
Phone:________________________ Fax:________________________ E-Mail:________
Letter Writing

What do you say in a letter?
- Write your own letter. Typed letters are easier to read, but handwritten letters are acceptable if they are legible. Your letter should not be longer than two pages.
- State your name, address, phone number, county you live in, e-mail address.
- State your reason for writing this letter. Explain how the issue affects you, your child, and those around you.
- Remember to tell your personal story. If possible, provide a photo of your child that you are writing about.
- Specifically, what are your concerns and questions? Be sure to include a question or request in the letter, so the person to whom you are writing can answer you.
- What would you like the person to whom you are writing to do about this situation? Say what you want, rather than what you don’t want.
- If you want a response to your letter, ask for one. What sort of response do you want:
  - A letter
  - A meeting
  - A phone call
  - Something else?

What else do you need to say in your letter?
- Put your return address in your letter. Envelopes can be thrown away.
- Be sure there is a date on your letter.
- Keep a copy of your letter for your records.
- Be sure to give an address or daytime phone number where you can be reached.
- Thank them for their time and attention they are giving to your problem/issue.

Some reasons for writing a letter are to:
- Discuss a problem
- Request an evaluation(s)
- Request a meeting
- Make contact with someone
- Request records
- Write a follow-up letter
- Give positive feedback

Other things:
- Have someone proofread your letters
- Include attachment(s)/enclosure(s)
- C: copies to all persons necessary
# Letter Log

Always keep a copy of every letter you write for your own records.

<table>
<thead>
<tr>
<th>Date</th>
<th>To Whom</th>
<th>From Whom</th>
<th>Reason for Letter</th>
<th>Reply</th>
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**Telephone Log**

Always keep a log of telephone calls made for your own records.

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<tr>
<th>Date</th>
<th>Time</th>
<th>Person Called</th>
<th>Reason for Calling</th>
<th>Response</th>
<th>Follow-Up</th>
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# Diet Tracking Form

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# Growth Tracking Form

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# Hospital Stay Tracking Form

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# Medical and Surgical Highlights

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<th>RESULT</th>
<th>COMMENTS</th>
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</table>
# Lab Work/Tests/Procedures

<table>
<thead>
<tr>
<th>DATE</th>
<th>TEST</th>
<th>RESULT</th>
<th>COMMENTS</th>
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Equipment

Medical Equipment Supplier (DME): ________________________________

Contact Person: ________________________________________________

Phone: _________________ Fax: _________________ E-Mail: ____________

Notes (Delivery schedule, order schedule, ECT.): ______________________

___________________________________________________________________

Equipment: ______________________________________________________

Description: _____________________________________________________________________

Date obtained: _________________ Service Schedule: _________________

Contact Person: _________________ Phone: __________________________

__________________________________________________________________________

Equipment: ______________________________________________________

Description: _____________________________________________________________________

Date obtained: _________________ Service Schedule: _________________

Contact Person: _________________ Phone: __________________________

__________________________________________________________________________

Equipment: ______________________________________________________

Description: _____________________________________________________________________

Date obtained: _________________ Service Schedule: _________________

Contact Person: _________________ Phone: __________________________

__________________________________________________________________________
# Supplies

Medical Equipment Supplier (DME): ________________________________

Contact Person: ________________________________

Phone: ___________  Fax: ___________  E-Mail: ___________

Address: __________________________________________

Notes (Delivery schedule, order schedule, etc...): __________________________

__________________________________________________________________________

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<th>ITEM</th>
<th>DESCRIPTION</th>
<th>QUANTITY</th>
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# Medical Bill Communication Log

<table>
<thead>
<tr>
<th>Account #</th>
<th>Provider</th>
<th>Date of Service</th>
<th>What bill is for:</th>
<th>Date of Contact</th>
<th>Time</th>
<th>Title</th>
<th>Name</th>
<th>Notes</th>
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6.8
Emergency Preparedness for
Children with Special Health Care Needs

Instructions for Parents

Dear Parent:

Children with special healthcare needs have very unique medical histories and require very special medical treatment. If an emergency physician does not have access to this important information, these children are in danger of delayed treatment, unnecessary tests, and even serious errors. It is extremely important, then, that parents and physicians work together to give emergency physicians access to the special information they need to properly care for children with very special healthcare needs.

To address this problem, the American Academy of Pediatrics and the American College of Emergency Physicians have developed the Emergency Information Form. This simple form is used to record health information for children with special healthcare needs and should be kept in multiple locations for easy access by physicians and emergency medical personnel.

To complete this important form, follow these easy instructions:

1. **GET THE FORM**: A copy has been provided for you in this notebook.
2. **FILL IT OUT**: Begin filling out the form to the best of your ability. Take the form to the child’s primary care physician or specialist and ask them to finish filling out the form.
3. **KEEP IT**: Keep 1 copy of the form in each of the following places:
   a. **DOCTORS**: On file with each of the child’s physicians, including specialists.
   b. **ER**: On file with the local emergency rooms where the child is most likely to be treated in the case of an emergency.
   c. **HOME**: At the child’s home in a place where it can be easily found, such as on the refrigerator.
   d. **VEHICLES**: In each parent’s vehicle (i.e., glove compartment).
   e. **WORK**: At each parent’s workplace.
   f. **PURSE/WALLET**: In each parent’s purse or wallet.
   g. **SCHOOL**: On file with the child’s school, such as in the school nurse’s office.
   h. **CHILD’S BELONGINGS**: With the child’s belongings when traveling.
   i. **EMERGENCY CONTACT PERSON**: At the home of the emergency contact person listed on the form.
4. **REGISTER**: Consider registering the child, if he or she is not already registered, with Medic Alert®. Send Medic Alert® a copy of the form so that they can keep it stored in their central database, which is easily accessible by emergency medical personnel.
5. **UPDATE**: It is extremely important that you update the form every 2-3 years, and after any of the following events:
   a. Important changes in the child’s condition.
   b. The performance of any major procedure.
   c. Important changes in the treatment plan.
   d. Changes in physicians.

Now, if your child ever has an emergency, the emergency medical personnel will have easy access to your child’s very unique medical history, allowing them to provide your child with the best medical care available.

Thank you for your cooperation!

Very truly yours,

American Academy of Pediatrics
American College of Emergency Physicians
Emergency Medical Services for Children

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American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000
# Emergency Information Form for Children With Special Needs

<table>
<thead>
<tr>
<th>Name:</th>
<th>Birth date:</th>
<th>Nickname:</th>
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<tr>
<th>Home Address:</th>
<th>Home/Work Phone:</th>
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<table>
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<tr>
<th>Parent/Guardian:</th>
<th>Emergency Contact Names &amp; Relationship:</th>
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<table>
<thead>
<tr>
<th>Signature/Consent*:</th>
<th></th>
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<table>
<thead>
<tr>
<th>Primary Language:</th>
<th>Phone Number(s):</th>
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## Physicians:

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<thead>
<tr>
<th>Primary care physician:</th>
<th>Emergency Phone:</th>
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<td>Fax:</td>
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<tr>
<th>Current Specialty physician:</th>
<th>Emergency Phone:</th>
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<td>Specialty:</td>
<td>Fax:</td>
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<th>Current Specialty physician:</th>
<th>Emergency Phone:</th>
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<td>Specialty:</td>
<td>Fax:</td>
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<th>Anticipated Primary ED:</th>
<th>Pharmacy:</th>
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<tr>
<th>Anticipated Tertiary Care Center:</th>
<th></th>
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## Diagnoses/Past Procedures/Physical Exam:

1. Baseline physical findings:

2. 

3. Baseline vital signs:

4. 

Synopsis:

Baseline neurological status:

*Consent for release of this form to health care providers
### Diagnoses/Past Procedures/Physical Exam continued:

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Significant baseline ancillary findings (lab, x-ray, ECG):</th>
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<tbody>
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<td>1.</td>
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<td>3.</td>
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<tr>
<td>4. Prostheses/Appliances/Advanced Technology Devices:</td>
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### Management Data:

**Allergies: Medications/Foods to be avoided**

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<th>3.</th>
<th>Procedures to be avoided</th>
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### Immunizations (mm/yy)

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<th>Dates</th>
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<tr>
<td>DPT</td>
<td>Hep B</td>
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<tr>
<td>OPV</td>
<td>Varicella</td>
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<tr>
<td>MMR</td>
<td>TB status</td>
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<tr>
<td>HIB</td>
<td>Other</td>
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**Antibiotic prophylaxis:**

- Indication: 
- Medication and dose:

### Common Presenting Problems/Findings With Specific Suggested Managements

<table>
<thead>
<tr>
<th>Problem</th>
<th>Suggested Diagnostic Studies</th>
<th>Treatment Considerations</th>
</tr>
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</table>

### Comments on child, family, or other specific medical issues:

Physician/Provider Signature: ___________________  Print Name: ___________________

Emergency Contact Person(s)

None:____

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<th>Name:</th>
<th>Relationship:</th>
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<td>Work Phone:</td>
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<td>Address:</td>
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<td>City:________________</td>
<td>State:____ Zip Code:____</td>
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<td>City:________________</td>
<td>State:____ Zip Code:____</td>
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Who else should be notified in the event of an emergency? (Clergy, other relatives, friends, etc...)

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<td>City:________________</td>
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Preferred Religion?  Y  N  None

Church:________________

Family’s religion and/or customs that may affect medical treatment of child:  Y  N
Transitioning: A Time of Change

Workbook

Your child and family will experience many transitions, small and large, over time. Three predictable transitions occur for most children: reaching school age, approaching adolescence, and moving from adolescence to adulthood. Children with special healthcare needs and/or disabilities do not experience these transitions in the way most children experience them. Other transitions may involve moving into new programs, working with new agencies and care providers, or making new friends. Transitions involve changes: adding new expectations, responsibilities, or resources and letting go.

The goal of this workbook is to organize the transition process into a smooth, successful move from pediatric focused to adult focused. Please feel free to use these pages as they seem to make sense for you. This workbook is not meant to substitute for other transition resources you may have available to you from the school system or community. Transition is a comprehensive process involving all facets of your life.

Looking at transitions may be hard, depending on your circumstances. You may have limited time just to do what needs to get done today. You may find it helpful, though, to jot down a few ideas about your child’s and family’s future. You might start by thinking about your child’s and family’s strengths. How can these strengths help you plan for “what’s next” and reaching long-term goals? What are your dreams and your fears about your child’s and family’s future?

This workbook is really about your child and family! The final decisions about what to include in these pages should ultimately be your decision. There is no rush, so be thoughtful about what you include as you walk through these pages. Most of all have fun! This is a great opportunity to learn more about your child’s health and how it can affect the rest of his/her life.
Suggestions for Transitioning to Adulthood

Teens and young adults should be active participants in the transition to adult services. This is a time for parental support without being overprotective. “Letting go” is a necessary process experienced by both parent and young adult. Where do you start? Choose a goal that your young adult feels is most important to his or her independence and identify “safety nets.” Safety nets are smaller steps taken to achieve independence and the support that is needed to assist them on their journey. Having these safety nets in place will make it much easier to transfer the responsibility to your young adult.

Following is a list of some of the health concerns parents should consider in their child’s transition to adulthood. *This does not include individuals whose disability requires legal guardianship by another person.*

< Guardianship
- At age 18, in most states, adolescents reach the age of majority and are expected to make decisions about their own care.
- Parents discover, by law, their young adult cannot be dependent forever.
- Begin to think and plan for YOUR future as your teen becomes a young adult.
- Please contact Sue Midland at (307)635-8422 for information on Guardianship.

< SSI (short for Supplemental Security Income)
- A person of any age can receive SSI, if they are disabled and meet the income and asset limits. In the case of minor children who live with their parents. We must also consider the parents’ income and assets. Once a child is 18 we no longer consider parental income or assets.
- Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or to result in death.
- For more information about benefits for your young adult, please contact the Social Security Administration at 1-800-772-1213.
- Take a look at SSA’s Listings of Impairments and analyze if your disability(ies) may qualify:

< Health care providers
- Allow time for your teen or young adult and the doctor to be alone during an appointment. It is important that he/she have time to ask the doctor questions when you are not present. This conveys to the doctor that they are competent to ask personal questions and get correct information.
- You and your young adult should talk to your doctor about his or her future medical needs.

< Health care after graduation from high school
- Who is responsible for making doctor appointments and getting prescriptions filled?
- Does your young adult know about his or her illness or disability?
- Do they know their rights to medical information, to decline services, and to understand complications of a medical procedure?
• Are they able to communicate their needs to the doctor or be comfortable in asking that all communication be written down to help them remember correctly?
• Who is responsible for hiring and firing live-in attendants to assist your young adult through the day or evening?
• There is a free guide you may find helpful in the decisions and choices ahead of you and your child: Parents’ Guide to Transition: What Happens After High School? You can find it on the internet at http://www.pluk.org/trans.html. It will answer many of the questions listed above as well as others. If you are unable to access this guide, call (307) 777-3637 and we will ship you a hard copy.

Addressing your young adult’s health needs on the job, Mental Health issues
• Who is responsible for scheduling of medication to be taken while at work?
• Is it necessary for an employer or a mentor to know about medications and the effects it could have on your young adult while they are at work? (Consider work schedule versus medication schedule.)
• Are there certain tasks and/or machinery that should not be assigned?

Sexuality
• What is sexuality? It is having friends, caring about others, being needed, being loved and having opportunities to be with others. It is also holding hands, putting a head on a shoulder, hugging, touching or kissing. Ignoring sexuality has profound effects on body image, self-identity and self-esteem in the teen or young adult.
• Knowing the answers to sexual questions reduces vulnerability. Parents are in the best position to teach sexuality to their teen or young adult. Parents are the constant in their child’s life and they know them best. If you need further resources to introduce your teen or young adult to his or her sexuality, don’t be afraid to ask for help. Disability organizations, parenting groups, teachers and doctors can provide resources and information.

Health insurance, medication and appliances
• The FIRST STEP is to read your insurance policy or call your claims representative at your insurance company to find out what age your young adult may lose coverage on the family health insurance.
• If your teenager turns 18, completes high school and does not go on for further schooling, he or she may no longer be eligible for the family’s insurance.

Involve your young adult in discussions about health care financing.
• Learn what questions to ask as you explore insurance options. Be sure the plan will meet your young adult’s needs. Here are some questions to consider:
  ▪ What are the specific needs of your young adult?
  ▪ What are the medication costs?
  ▪ Does the plan cover home care?
  ▪ Does the plan cover durable medical equipment (i.e., wheelchair, glucose monitors)?
  ▪ Is physical, occupational or speech therapy covered in the plan?
My Story

My hobbies are:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

My favorite things are:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

I am unique because:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

The activities I am involved in are:
_________________________________________________________________________________
_________________________________________________________________________________
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In five years I hope to:
_________________________________________________________________________________
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Use the back of this page to write other interesting information about yourself that you would like for your new doctor to know. Do you have any fears or concerns about the transition process?
Family Information

My name: _______________________________ Nickname(s): __________________
Date of Birth: ______________________ Social Security Number: _________________
Address: __________________________________________ ______________________
Phone number: _____________________________________ ______________________

Emergency Contact Person:__________________________ _______________________
Daytime Phone: ________________________ Evening Phone: _____________________
Relationship to me: _______________________________ ________________________
Address: __________________________________________ ______________________

Guardian (if “self” please indicate) ___________________________________________
Daytime Phone: ________________________ Evening Phone: _____________________
Relationship to me: _______________________________ ________________________
Address: __________________________________________ ______________________

Parent’s Names: ___________________________________ _______________________
Daytime Phone: ________________________ Evening Phone: _____________________
Address: __________________________________________ ______________________
Contact in an Emergency? __________________________________________________

Siblings Names: _________________________ ____________________
_________________________ ____________________ _________
Contact in an Emergency? __________________________________________________
Provide Contact Information: ________________________________________________

People who live with me:
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________
Name: _______________________________ Relationship: ______________________

7.5
Community Contact Information:

School Name: ______________________________________ ______________________
Grade or year in school: __________________________ __________________________
School Phone: ____________________ Contact Person: __________________________
Academic Counselor: ________________________ Phone: _______________________

Local Public Health Office: __________________________
Case Manager/Title: ____________________________________________
Address: ________________________________________________________
Daytime phone: _______________ Evening Phone: _______________
Fax: ______________________

Other Case Management: ____________________________ _______________________
Case Manager/Title: _______________________________ ________________________
Address: __________________________________________ ______________________
Daytime phone: _____________________ Evening Phone: ___________________
Fax: ______________________

Durable Medical Equipment Company: ___________________________
Case Manager/Title: ____________________________________________
Address: ________________________________________________________
Daytime phone: _______________ Evening Phone: _______________
Fax: ______________________

Church or Religious Community: ____________________________
Daytime Phone: __________________________ Evening Phone: _______________
Address: ________________________________________________________
Contact in an Emergency? ____________________________

Other Important Personal or Family Information Please Continue on the back of this page.
Household Emergency Information

My Address: ____________________________________________________________
Directions to my house:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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Fire Department Number: 911 or ________________________________
Police Department Number: 911 or ________________________________
Ambulance: 911 or ________________________________________________
Poison Control Hotline: ___________________________________________

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Fire Escape Plan:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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Check smoke alarms monthly!

Check fire extinguishers monthly!
Care Plan for Behavior Disorders

Crisis Hotline: ___________________________ Case Manager Phone: ________________
Family contact person: ___________________ Phone: ____________________________

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What behavior pattern is typical for this individual? Include affect, seasonal changes etc.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Worrisome Behavior to Watch for:

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Action Plan:
1. ___________________________________________ 
2. ___________________________________________ 
3. ___________________________________________

Intermediate Dangerous Behavior:

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Action Plan:
1. ___________________________________________ 
2. ___________________________________________ 
3. ___________________________________________

Dangerous Behavior:

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Action Plan:
1. ___________________________________________ 
2. ___________________________________________ 
3. ___________________________________________

Extremely Dangerous Behavior: CALL 911
Care Plan for Medical Disorders

Physician Call Center Number: ____________  Case Manager Phone: ________________
Family contact person: ________________  Phone: ________________

What medical symptoms are typical for this individual? Include affect, behavioral problems, physical symptoms etc. of frequently occurring illnesses.

Worrisome Symptoms to Watch for:

Action Plan:
1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________

Worsening Symptoms:

Action Plan:
1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________

Dangerous Symptoms:

Action Plan:
1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________

Life Threatening Situations: CALL 911
Medical Summary Reflecting the Most Recent Complete Physical Examination

Insert a copy of the most recent history and physical exam done by your primary care doctor. If you have several specialists include their most recent report summarizing your care.

- Have you thought about gynecological issues such as contraception?
- Are there any other concerns that need to be discussed dealing with family planning or sexuality?
- Are there any serious ongoing issues that are in the process of being evaluated or any recent changes to medicines or therapies?
## Current Medication Summary Sheet

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Date Started</th>
<th>Date Ended</th>
<th>Dosage</th>
<th>Frequency Given</th>
<th>Reason For Taking</th>
<th>Observed Side Effects</th>
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<tbody>
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## Medications That Didn’t Work

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Date Started</th>
<th>Date Ended</th>
<th>Dosage/Frequency</th>
<th>Reason for Stopping</th>
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</table>
Immunization History

Insert a copy of your immunization record here.

Disease History:
Chicken Pox ___________________
Hepatitis B ___________________
Hepatitis A ___________________
Other_________________________
Doctor Contact Information

Primary Care Provider: ____________________________________________________________
Address: ______________________________________________________________________
Phone: __________________ Fax: _________________________________________________
Emergency/After Hours Number: _________________________________________________

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Counselor/Therapist: _____________________________________________________________
Address: ______________________________________________________________________
Phone: __________________ Fax: _________________________________________________
Emergency/After Hours Number: _________________________________________________

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Specialist Provider: ____________________________ Specialty: _______________________
Address: ______________________________________________________________________
Phone: __________________ Fax: _________________________________________________
Emergency/After Hours Number: _________________________________________________

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Specialist Provider: ____________________________ Specialty: _______________________
Address: ______________________________________________________________________
Phone: __________________ Fax: _________________________________________________
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Emergency/After Hours Number: _________________________________________________

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<td>Emergency/After Hours Number:</td>
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<table>
<thead>
<tr>
<th>Dentist:</th>
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<tbody>
<tr>
<td>Address:</td>
<td>Fax:</td>
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<tr>
<td>Phone:</td>
<td>Fax:</td>
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<tr>
<td>Emergency/After Hours Number:</td>
<td></td>
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</tbody>
</table>
Physical Therapist: _______________________________ _______________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

Occupational Therapist: ___________________________ _______________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

Speech-Language Pathologist: ______________________ _______________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

Eye Care Provider: _______________________________ _______________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

Other: ____________________________________________ _____________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

Other: ____________________________________________ _____________________
Address: __________________________________________ ______________________
Phone: _______________________________ Fax: _______________________________
Emergency/After Hours Number: __________________________________________ 

7.15
We encourage you to take the next section of documents to your healthcare professional(s), this way the proper information can be filled in correctly.
Care Summary Sheet – Primary Care

Date: ____________________   Contact Number: ______________
Provider: _________________________________________
Reason for visit:
___________________________________________________
___________________________________________________

Diagnosis:
___________________________________________________
___________________________________________________

Treatment: _________________________________________

Follow Up Appointment: ____________________________

Do you anticipate transition from your care to another provider for adult services?
If so, do you have an adult provider to refer this patient to?
___________________________________________________

Care Summary Sheet – Specialist

Date: ____________________   Contact Number: ______________
Provider: _________________________________________
Reason for visit:
___________________________________________________
___________________________________________________

Diagnosis:
___________________________________________________
___________________________________________________

Treatment: _________________________________________

Follow Up Appointment: ____________________________

Do you anticipate transition from your care to another provider for adult services?
If so, do you have an adult provider to refer this patient to?
___________________________________________________

7.17
Care Summary Sheet – Specialist

Date: ____________________   Contact Number: ________________
Provider: __________________________ Specialty: __________________________
Reason for visit:

________________________________________________________________________

Diagnosis:

________________________________________________________________________

Treatment : ____________________________________________________________

Follow Up Appointment: ________________________________________________

Do you anticipate transition from your care to another provider for adult services?
If so, do you have an adult provider to refer this patient to?

________________________________________________________________________
Care Summary Sheet – Dentist

Date: ____________________   Contact Number: ________________
Provider: _______________________________________________________
Reason for visit:
_________________________________________________________________
_________________________________________________________________

Diagnosis:
_________________________________________________________________
_________________________________________________________________

Treatment : _______________________________________________________

Follow Up Appointment: __________________________________________

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?
_________________________________________________________________

Care Summary Sheet – Eye Care

Date: ____________________   Contact Number: ________________
Provider: _______________________________________________________
Reason for visit:
_________________________________________________________________
_________________________________________________________________

Diagnosis:
_________________________________________________________________
_________________________________________________________________

Treatment : _______________________________________________________

Follow Up Appointment: __________________________________________

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?
_________________________________________________________________
Care Summary Sheet – Counselor Therapist

Date: ____________________          Contact Number: ______________
Provider: __________________________________________________________
Reason for visit:

Diagnosis: Axis I ___________________________________________________
            Axis II _____________________________________________________
            Axis III ___________________________________________________
            Axis IV ___________________________________________________

Treatment Goal: _____________________________________________________

Treatment Method:

Follow Up Appointment: ____________________________ _______________________

Do you anticipate transition from your care to another provider for adult services?  
If so, do you have an adult provider to refer this patient to?

Care Summary Sheet – Psychiatry

Date: ____________________          Contact number: ______________
Provider: __________________________________________________________
Reason for visit:

Diagnosis: Axis I ___________________________________________________
            Axis II _____________________________________________________
            Axis III ___________________________________________________
            Axis IV ___________________________________________________

Treatment Goal: _____________________________________________________

Treatment Method:

Follow Up Appointment: ____________________________ _______________________

Do you anticipate transition from your care to another provider for adult services?  
If so, do you have an adult provider to refer this patient to?
Insurance Information

The **FIRST STEP** is to read your insurance policy or call your claims representative at your insurance company.

Involv[e](#)e yourself and your parents in discussions about healthcare financing.

Learn what questions to ask as you explore healthcare financing. Be sure the plan will meet your needs. Below are questions to consider:

- What are my specific needs?
- What are my out of pocket expenses? Medication costs?
- Do I need a referral?
- Does my insurance change with age or school status?
- Does my insurance change with employment status?
- If my insurance changes, are there certain services that will be less available after I reach a certain age?
- Does the plan cover home care?
- Does the plan cover durable medical equipment (e.g., wheelchair, glucose monitors, etc...)?
- Is physical, occupational, or speech therapy covered in the plan?

**IF YOU CAN’T ANSWER THE QUESTIONS ABOVE, THE TIME TO FIND OUT ABOUT YOUR COVERAGE IS NOW!!**

Primary Insurance: ____________________________  Plan number: ________________
Group number: ________________________________  ID number: ________________
Subscriber’s name: ________________________________ ________________________
Subscriber’s Social Security Number: ______________ ___________________________
Mailing address: __________________________________ ________________________
Phone: ______________________________  Fax: ______________________________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Secondary Insurance: ____________________________  Plan number: ______________
Group number: ________________________________  ID number: ________________
Subscriber’s name: ________________________________ ________________________
Subscriber’s Social Security Number: ______________ ___________________________
Mailing address: __________________________________ ________________________
Phone: ______________________________  Fax: ______________________________

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7.21
Insurance Considerations

Adult Home and Community-Based Waiver
http://wdh.state.wy.us/ddd/waiver.asp

- In order to be eligible for the adult waiver, an individual must be no younger than 21 years of age, a citizen of the United States, and a resident of Wyoming. They must be mentally retarded or meet the federal definition for developmental disabilities and they must be eligible to receive the level of care of an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

WYOMING HEALTH INSURANCE POOL (WHIP)
http://insurance.state.wy.us/consumfm/pdf/WHIP%20Brochure%204-06.pdf

- The Wyoming Health Insurance Pool was created by the 1990 Wyoming Legislature to provide health insurance coverage to residents of Wyoming who are denied adequate health insurance. This plan is specially designed to meet the needs of those individuals who are unable to purchase health insurance for themselves because of existing health problems

Social Security Income (SSI)

- A person of any age can receive SSI, if they are disabled and meet the income and asset limits. In the case of minor children who live with their parents. We must also consider the parents’ income and assets. Once a child is 18 we no longer consider parental income or assets
- Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or to result in death
- For more information about benefits for your young adult, please contact the Social Security Administration at 1-800-772-1213
Department of Family Services
http://dfsweb.state.wy.us/

- Parent(s) with children who have qualifying income.
- Pregnant women.
- Children through the age of 18
- A child with special health needs who may be eligible for the Children’s Special Health (CSH) program.
- Individuals receiving Supplemental Security Income (SSI) through Social Security.
- Individuals no longer receiving Supplemental Security Income (SSI) through Social Security.
- Individuals receiving Social Security benefits who are eligible for Medicare Part B Insurance.
- Individuals in need of nursing home care.
- Individuals who need care in an Assisted Living Facility
- Individuals who are developmentally disabled.
- Individuals who need nursing home care but wish to remain in their home.
- Individuals who are disabled and working.
- Individuals who are in need of hospice care.
- Individuals with an acquired brain injury.
- Individuals who need help with prescription drugs.
- Individuals who are qualified or non-qualified aliens.

Prescription Drug Assistance Program
http://wdh.state.wy.us/pharmacy/PDAP.asp

The Prescription Drug Assistance Program is a state funded pharmaceutical assistance program. For qualifying individuals, the benefit allows three (3) prescriptions per month. Prescriptions are limited to a month’s supply and the co-pay is $10 per prescription for a generic drug and $25 per prescription for a brand-name drug. Eligibility for the program is determined by the Department of Family Services and clients are eligible for a period of one year.
Mental Health Testing and Monitoring

*Insert copies of any psychological testing results done to date in this section. If applicable include the most recent Ames test for psychotropic medication monitoring.*
Other Transition Areas To Consider:

If you have one, a copy of your most recent IEP should be included here.

Other questions to answer are:

• Do I need a vocational rehabilitation advisor to transition from school to work? If yes…

Name of Contact: ________________________________________________________________
Phone number: __________________________________________________________________
Date Contact Initiated: __________________________________________________________________
First Meeting Date: __________________________________________________________________
TO DO List Prior to the First Meeting:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

• Do I need an independent living advisor to transition from home to adult living? If yes…

Name of Contact: ________________________________________________________________
Phone number: __________________________________________________________________
Date Contact Initiated: __________________________________________________________________
First Meeting Date: __________________________________________________________________
TO DO List Prior to the First Meeting:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

• Do I need any additional help transitioning from secondary school to college or technical school? If yes…

Name of Contact: ________________________________________________________________
Phone number: __________________________________________________________________
Date Contact Initiated: __________________________________________________________________
First Meeting Date: __________________________________________________________________
TO DO List Prior to the First Meeting:
____________________________________________________________________________________
____________________________________________________________________________________
• Do I need help managing my transportation needs in order to meet my transition goals? If yes...

Name of Social Worker: ______________________________________________________
Phone number: _____________________________________________________________
Date Contact Initiated: _______________________________________________________
First Meeting Date: _________________________________________________________
TO DO List Prior to the First Meeting:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

• Do I have any other needs that need to be met prior to implementing my transition plan? If yes list them here and talk to your doctor.

CONGRATULATIONS!!!

YOU’RE READY TO TRANSITION!!
## Glossary of Commonly Used Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Advocate</td>
<td>An advocate is someone who can listen to your problems and ideas, this person will help you make decisions or final solutions.</td>
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<tr>
<td>ADA</td>
<td>Americans with Disabilities Act – A law that supplements civil rights legislation enacted under the Rehabilitation Action Act. ADA prohibits discrimination against individuals with disabilities.</td>
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<tr>
<td>Assessment</td>
<td>A way of collecting information about a child’s needs, strengths, and interests.</td>
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<tr>
<td>Care Coordination</td>
<td>Services are provided in a manner that the family’s lifestyle is interrupted as little as possible, and the family’s and child’s needs are met.</td>
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<tr>
<td>Case Manager</td>
<td>A person who works with the family to plan for services and who coordinates many service providers. (Also called a Service Coordinator)</td>
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<tr>
<td>Chronic</td>
<td>A description of an illness/condition which lasts throughout a person’s life.</td>
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<tr>
<td>Community-Based</td>
<td>High quality services necessary to meet the daily needs of the child and his/her family located near their home.</td>
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<tr>
<td>Confidentiality</td>
<td>Your child’s records and information will be shared only with people directly involved in your child’s care, (e.g., medical or educational providers, etc.) which uphold the child’s right to privacy.</td>
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<tr>
<td>CSH</td>
<td>Children’s Special Health - A state program to assist children who have special health care needs.</td>
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<td>DDD</td>
<td>Division of Developmental Disabilities</td>
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<tr>
<td>Diagnosis</td>
<td>The name of a condition or illness.</td>
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<td><strong>Disability</strong></td>
<td>The result of any physical or mental condition that affects a person’s ability to develop, achieve or function.</td>
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<td><strong>Discharge Planning</strong></td>
<td>A plan for continuing care after your child has a hospital stay. Another goal of discharge planning is to help the health care team make sure your child has the resources that he/she needs in their community.</td>
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<tr>
<td><strong>DFS</strong></td>
<td>Department of Family Services.</td>
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<td><strong>DME</strong></td>
<td>Durable Medical Equipment - Health care equipment that can be used over and over again (e.g., hospital beds, ventilators, I.V. Poles, wheelchairs, and walkers).</td>
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<tr>
<td><strong>EI</strong></td>
<td>Early Intervention - Part C serves children 0 to 6 years of age and their families.</td>
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<tr>
<td><strong>Eligible</strong></td>
<td>Meeting specific requirements to qualify for a program or service.</td>
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<td><strong>EPSDT</strong></td>
<td>Early Periodic Screening Diagnosis and Treatment.</td>
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<tr>
<td><strong>Evaluation</strong></td>
<td>A way of collecting information about a child’s needs, strengths, and interests.</td>
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<td><strong>Family-Centered Care</strong></td>
<td>Services are delivered in a way that respects the central role of the family as caregiver, advocate, and decision-maker for the child.</td>
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<tr>
<td><strong>Genetic Disease or Disorder</strong></td>
<td>A disease that passes by gene from parent to child.</td>
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<tr>
<td><strong>Health Care Professionals</strong></td>
<td>Workers who have healthcare skills (including nurses, doctors, social workers, physical therapists, pharmacists, and so on).</td>
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<tr>
<td><strong>HMG-SK</strong></td>
<td>Help Me Grow-Safe Kids</td>
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</table>
HMO  
Health Maintenance Organization - A medical insurance program which gives care through specified doctors and hospitals. Members pay a fixed prepaid premium.

Inclusive Education  
Children with special needs are educated with children that do not have special needs. Classroom assignments are adapted so the child with special needs can interact with the other children in the class.

IDEA  
Stands for *Individuals with Disabilities Education Act*, from the federal law “Education for all Handicapped Children Act” (P.L. 94-142). A student must be enrolled in special education in order to receive the services mandated by IDEA. Students with a wide range of disabilities may be eligible for special education and related services.

IEP  
Individualized Education Plan - A special education service plan for your child required by law for all students receiving special education services. The IEP outlines your child’s educational goals and any services or assistance your child needs to meet those goals.

IFSP  
Individual Family Service Plan - A service plan for a child 1-36 months of age and their family. The IFSP outlines services and goals of the family with the service providers. It can include services from human services departments and public and private agencies.

LRE  
Least Restrictive Environment - This means a child with special needs is educated as much as possible with children who do not have special needs. The school program should still meet all of the child’s educational needs. (“Mainstream”, “Integration”, “Inclusion”).
| **O.T./OT** | Occupational Therapy - Treatment to help a person develop mental or physical skills to aid in daily living. It focuses on hand and finger movement, and self-help skills such as dressing or using a fork and spoon. |
| **Pediatric** | A branch of medicine dealing with the care of children. |
| **Pediatric Specialist** | 1. A pediatrician who has a specialty area of knowledge and skills. Examples are pediatric oncologist and neonatologist.  
2. A physician specialist who completed special training to treat children. The physician could be a pediatric surgeon, pediatric anesthesiologist or a pediatric urologist, for example. |
<p>| <strong>Pediatrician</strong> | A doctor who specializes in the care of children. |
| <strong>PHN</strong> | Public Health Nurse. |
| <strong>Primary Care Provider</strong> | A physician or clinician whose practice focuses upon internal medicine, family/general practice, pediatrics, and obstetrics/gynecology. |
| <strong>P.T./PT</strong> | Physical Therapy - Treatment of physical disabilities by a physical therapist. It includes the use of massage and exercise to help the person improve the use of bones, muscles, joints, and nerves. |
| <strong>PL</strong> | Public Law - Federal law that is passed. The number that follows “PL” identifies the law, (E.g., PL 101-476). |
| <strong>Respite (Pronounced RES-pit.)</strong> | Care for a limited time, in which a family gets a much needed “break” from caring for their child with special needs. |</p>
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<td>A person who works with the family to plan for services and who communicates with many service providers (Also called Case Manager).</td>
</tr>
<tr>
<td>S.S.I./SSI</td>
<td>Supplemental Security Income - A cash assistance federal program that pays benefits to children with disabilities under age 18 whose families have limited income or resources. You can get more information by calling 1-800-772-1213.</td>
</tr>
<tr>
<td>Special Needs</td>
<td>A term used to describe persons with one or more mental, emotional, or physical conditions that limit their capacity to participate in normal activities.</td>
</tr>
<tr>
<td>W.I.C./WIC</td>
<td>The Special Supplemental Food Program for Women, Infants and Children - A program that provides food and nutrition education to prevent or correct malnutrition in pregnant women, new mothers and children up to age five. The program also screens for other health problems and makes referrals to other health and social services.</td>
</tr>
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Resources

Connect Wyoming 307-766-2996
Laramie, WY  82071

Connect Wyoming is a human services infrastructure designed to service the state of Wyoming. It consists of a website hosting a searchable version of the Pathway’s Plus database, a calendar of human service events, a monthly newsletter, and special Pathway’s search interfaces for Medicaid Waiver Providers, Senior Services and the Wyoming Breast Cancer Resource Directory. The Pathways Plus database contains more than 3400 human service programs, and a browseable version is available on a free CD. Finally, Connect Wyoming forms partnerships with other agencies to produce specialized print directories, web interfaces, and other information formats.

Pathways Plus Services http://wind.uwyo.edu/connect/default.asp

The Pathways Plus database provides the most current and comprehensive access to human services information in the state. Pathways has been designed so that the information contained in the database can be extracted and used in a variety of ways. Services currently provided through Pathways Plus include:

• Online searching (Basic and Advanced)
• Online subject browsing
• Browseable desktop version
• Print directories for each county available through the website
• Special search pages for Seniors, Breast Cancer, and Medicaid Waiver Providers

Pathways Plus services are constantly growing and improving. Please check the site often for the latest development.

Included in this Packaging Wisdom notebook is a copy of Connect Wyoming CD. You can also access the information at http://wind.uwyo.edu/connect/default.asp
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<thead>
<tr>
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<tr>
<td><strong>Albany County Public Health</strong></td>
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<tr>
<td><strong>Big Horn County Public Health</strong></td>
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<td>Greybull Office</td>
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<tr>
<td>Lovell Office</td>
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<tr>
<td><strong>Campbell County Public Health</strong></td>
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<tr>
<td><strong>Carbon County Public Health</strong></td>
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<tr>
<td>Rawlins Office</td>
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<tr>
<td>Saratoga Office</td>
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<tr>
<td><strong>Converse County Public Health</strong></td>
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<tr>
<td>Douglas Office</td>
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<tr>
<td>Glenrock Office</td>
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<tr>
<td><strong>Crook County Public Health</strong></td>
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<tr>
<td><strong>Fremont County Public Health</strong></td>
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<tr>
<td>Lander Office</td>
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<td>Riverton Office</td>
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<tr>
<td><strong>Goshen County Public Health</strong></td>
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<td><strong>Hot Springs County Public Health</strong></td>
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<td><strong>Johnson County Public Health</strong></td>
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<td><strong>Laramie County Public Health</strong></td>
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<td><strong>Lincoln County Public Health</strong></td>
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<td>Kemmerer Office</td>
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<td>Afton Office</td>
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<td><strong>Natrona County Public Health</strong></td>
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<td><strong>Niobrara County Public Health</strong></td>
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<td><strong>Park County Public Health</strong></td>
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<tr>
<td>Cody Office</td>
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<tr>
<td>Powell Office</td>
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<td><strong>Platte County Public Health</strong></td>
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<td><strong>Sheridan County Public Health</strong></td>
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<td><strong>Sublette County Public Health</strong></td>
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<td><strong>Sweetwater County Public Health</strong></td>
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<tr>
<td>Rock Springs Office</td>
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<tr>
<td>Green River Office</td>
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<tr>
<td><strong>Teton County Public Health</strong></td>
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<tr>
<td><strong>Uinta County Public Health</strong></td>
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<tr>
<td>Evanston Office</td>
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<tr>
<td>Lyman Office</td>
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<tr>
<td><strong>Washakie County Public Health</strong></td>
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<tr>
<td><strong>Weston County Public Health</strong></td>
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