

Transition Summary

Name _____ DOB _____ SS# _____

Address _____

Street City State Zip

Phone _____

Home Work Cell

Emergency Contact _____

Relationship Phone

Guardian/Medical Surrogate _____

Relationship Phone

Primary Insurance: _____

Policy # Case Manager Phone #

Secondary Insurance: _____

Policy # Case Manager Phone #

Unique Communication/Cultural Needs: _____

Strengths/Assets: _____

Assistive Technology: _____

Allergies: _(meds & food) _____

Height: _____ Weight: _____ Dietary/Nutritional Needs: _____

Bowel Program: _____

Bladder Program: _____

Head/Neurology	GI
EENT	GU
Heart/Lungs	MS

Diagnosis	Managing Provider	Address	Phone
1.			
2.			
3.			
4.			
5.			

Current Medications	Current Medications
1.	5.
2.	6.
3.	7.
4.	8.

Current Therapies	Frequency	Provider	Contact Information
1.			
2.			
3.			

Recent Labs/ X-Rays	Date	Where on File	Findings

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Medical Equipment	Medical Supplies	Provider	Contact Information
1.			
2.			
3.			
4.			

Orthotics & Prosthetics	Provider	Contact Information
1.		
2.		

Past Hospitalizations (including surgeries)			
Date	Hospital Name	Reason	Physician

Functional Capabilities	Brief Summary
Upper Extremities	
Lower Extremities	
Speech/Language	
Cognitive/ Problem Solving	
Vision/Hearing	

Future Plans (including agencies involved, referral, appointments made)
Health Care
Health Care Insurance
School & Work
Independent Living (housing, transportation, attendant care)

Services Currently Receiving	Provider Contact Information
1.	
2.	
3.	
4.	

Signature Youth/Guardian: _____ Date Completed: _____

Signature Care Coordinator: _____ Phone #: _____

