

*Sample Individual Health Plan*

**Name:** \_\_\_\_\_ **Date of Last Revision:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Address/Phone/Parents:** \_\_\_\_\_

**Primary Doctor:** \_\_\_\_\_  
**Address/Phone:** \_\_\_\_\_

**Principal Diagnosis:** \_\_\_\_\_

<b>Problem List:</b>	<b>Consultants/Hospital/Phone/Date Last Seen:</b>
1. _____	_____
2. _____	_____
3. _____	_____

**Hospital Admissions in the last 12 months**  
Reason/Outcome/Discharge Date:

1. \_\_\_\_\_
2. \_\_\_\_\_

**Current Medications:**  
Dosage/Frequency/Method of Administration/Reason for taking/Prescribed by/Date started/effectiveness/side effects

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Allergies:**  
\_\_\_\_\_  
\_\_\_\_\_

**Equipment:**  
Type of equipment/company providing equipment/date prescribed/new equipment needed  
\_\_\_\_\_  
\_\_\_\_\_

**Home Care:**

Name of agency/phone/address/contact person/services provided

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**Public Programs Involved/Services provided:** example: public health, school, therapy companies, etc.

Name of agency/contact person/services provided

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**Medical History:**

Dates of diagnoses/surgeries/hospitalizations/treatments/significant changes

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**Review of Body Systems:**

Issue/How does it impact child/treatment/effectiveness/doctor treating/date of last doctor visit/unresolved issues/tests needed

Nutrition/swallowing: _____	Dental: _____
Vision: _____	Cardiac: _____
Hearing: _____	Renal: _____
Communication: _____	Endocrine: _____
Respiratory: _____	Gastrointestinal: _____
Orthopedic: _____	Skin Integrity: _____

**Potential Problems :**

Changes/issues to watch/plan to address changes

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**Team Goals:**

Date of last meeting/issues addressed/plan developed/timelines/follow-up/test results/insurance or coverage issues

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