

## TRANSITION PLAN

**PATIENT NAME:** Click or tap here to enter text. **DATE OF BIRTH:** Click or tap to enter a date.

**ADDRESS:** Click or tap here to enter text.

**Email** Click or tap here to enter text.

**Phone Number** Click or tap here to enter text. **Best time to reach** Click or tap here to enter text.

**Health Insurance Plan (Group & ID #)** Click or tap here to enter text.

**Race/Ethnicity:**

Caucasian  African American  Asian/Pacific islander  Native American  Alaska Native

Other (Specify): Click or tap here to enter text.

Hispanic  Not Hispanic

**Marital Status:** Choose an item.

### Brief Narrative Summary

Click or tap here to enter text.

### DIAGNOSIS

**Primary** Click or tap here to enter text.

**Secondary** Click or tap here to enter text.

**STRENGTHS:** (*Assets, resources, social support and natural positives of the patient and family*)

Click or tap here to enter text.

**ABILITIES:** (*Skills, aptitudes, capabilities, talents, and competencies of the patient and family*)

Click or tap here to enter text.

**NEEDS:** (*Identify patient treatment needs*)

Problems List	Details/Recommendations
<input type="checkbox"/> Hearing/Vision	
<input type="checkbox"/> Communication	
<input type="checkbox"/> Learning	
<input type="checkbox"/> Neurocognitive/Sensory	
<input type="checkbox"/> Orthopedic/Musculoskeletal	
<input type="checkbox"/> Stamina/Fatigue	
<input type="checkbox"/> Tumor	
<input type="checkbox"/> Dermatological	
<input type="checkbox"/> Behavioral/Psychological	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Other	

**PREFERENCES:** (*Identify patient preferences for treatment/transition*)

Click or tap here to enter text.

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## TRANSITION GOALS

Goals	Barriers/Concerns	Actions Needed	Person Responsible	Target Date

## PROVIDERS, SUPPORT SYSTEMS AND SERVICES

SERVICE/AGENCY	LOCATION/ADDRESS	PHONE	CONTACT Provider Name	APPOINTMENT DATE

## MEDICATIONS Not applicable

MEDICATION/DOSE	EFFICACY	NEXT FILL DATE

## Medication Reactions: None Noted Adverse reactions noted

Medication	: Allergic or Adverse Reaction

## Baseline

**Height** Click or tap here to enter text.

**Weight** Click or tap here to enter text.

**Respiration** Click or tap here to enter text.

**Heart rate** Click or tap here to enter text.

**Blood Pressure** Click or tap here to enter text.

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## Prior Surgeries, Procedures, Hospitalizations

**Date** Click or tap to enter a date. **Procedure/Hospitalization:** Click or tap here to enter text.

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**Date** Click or tap to enter a date. **Procedure/Hospitalization:** Click or tap here to enter text.

## Recent labs & radiology Not Applicable

**Test** Click or tap here to enter text. **Result** Click or tap here to enter text. **Date** Click or tap to enter a date.

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**Test** Click or tap here to enter text. **Result** Click or tap here to enter text. **Date** Click or tap to enter a date.

## Equipment, Appliances, and Assistive Technology None Noted

<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Crutches
<input type="checkbox"/> Walker	<input type="checkbox"/> Adaptive Seating	<input type="checkbox"/> Communication Device
<input type="checkbox"/> Gastrostomy	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Suctions
<input type="checkbox"/> Nebulizer	<input type="checkbox"/> CPAP	<input type="checkbox"/> Apnea Monitor
<input type="checkbox"/> O2 Monitor	<input type="checkbox"/> Cardiac Monitor	<input type="checkbox"/> Glucose Monitor
<input type="checkbox"/> Other		

## Emergency Plan Not Applicable

Emergent Issues	Suggested Interventions	Treatment Considerations

- Personal Safety Plan Prepared (attached)
- Supported decision making legal documents available (attached)
- Release of information documents prepared (attached)

## CONTACT PERSON(S): (who to contact at sending agency – name and phone number)

Click or tap here to enter text.

## TRANSITION PLAN PARTICIPANTS (Print Name, Credentials, Identity of plan participants):

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Patient Name: Click or tap here to enter text.

# TRANSITION PLAN

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Patient Signature

Date

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Parent/Caregiver Signature

Date

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Medical Provider Signature

Date

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Patient Name: Click or tap here to enter text.