UNIVERSITY OF ILLINOIS CHICAGO

Division of Specialized Care for Children

Resuscitation Status:
❑ Discussed ❑ Not Discussed
❑ Report Attached

Date Completed: _____ **Date of Last Revision:** _____

PORTABLE MEDICAL SUMMARY

Name:		Birth Date:
❑ Male ❑ Female	Email:	Home Phone:
Address:		Mobile Phone:
		Work Phone:
Guardian/Surrogate:	Relationship:	Home Phone:
		Mobile Phone:
Emergency Contact:	Relationship:	Home Phone:
		Mobile Phone:

Healthcare Providers

Pediatric		**Adult**	
Name:	Phone:	Name:	Phone:
Specialty:	Fax:	Specialty:	Fax:
Name:	Phone:	Name:	Phone:
Specialty:	Fax:	Specialty:	Fax:
Name:	Phone:	Name:	Phone:
Specialty:	Fax:	Specialty:	Fax:
Name:	Phone:	Name:	Phone:
Specialty:	Fax:	Specialty:	Fax:
Name:	Phone:	Name:	Phone:
Specialty:	Fax:	Specialty:	Fax:

Allergies/Sensitivities	**Reaction**	**Date**	**Allergies/Sensitivities**	**Reaction**	**Date**
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Medicines, Food & Procedures to be Avoided	**Reaction**	**Date**
1.		
2.		
3.		

Diagnosis(es)		**Problem List**
Height:	**Weight:**	
Baseline Vitals:		**Mobility/Transfer Status:**
Baseline Neurological Status:		❑ **Medication Record Attached**
		❑ **Immunization Record Attached**

Patient Name: _____ **DOB:** _____

Baseline Abnormal Physical Findings and Labs	

Pertinent Surgeries/Procedures	Date	Pertinent Surgeries/Procedures	Date

Recent or Important Hospitalizations: Diagnosis(es) & Treatment Summary	Hospital	Date

Additional Notes

Transition Goals	Plan
1.	
2.	
3.	

Patient Signature:	**Date:**
Parent/Guardian Signature:	**Date:**
Provider Signature:	**Date:**

Patient Name: _____ **DOB:** _____

EXPANDED INFORMATION

Therapies/Other Services (therapies, vocational, educational, home-based services, care coordination)

Type	Frequency	Provider	Phone

Maintenance Routines (e.g., bowel/bladder, respiratory, nutrition, etc.)

1.	4.
2.	5.
3.	6.

Equipment/Supplies

❑ Trach tube type:		❑ Nebulizer		❑ Feeding Pump		❑ Wheelchair	
Size:		❑ Orthotics/Prosthetics		❑ Crutches		❑ Communications Device	
❑ G-tube type:		❑ Suction Machine/Supplies		❑ Glucose Monitor		❑ Walker	
cm:		❑ O2 Stationary/Portable		❑ BP Monitor		❑ Hearing Aid	
❑ Vent type:		❑ Assistive Devices for ADLs		❑ Cardiac Monitor			
❑ Pulse ox:		❑ Apnea Monitor		❑ Other			

Instructions and Contact Information for Supply Orders:

Additional Information

Patient Signature:	**Date:**
Parent/Guardian Signature:	**Date:**
Provider Signature:	**Date:**

Patient Name: _____ **DOB:** _____

Medications/Supplements	Dosage	Time	Purpose	Possible Side Effects

Patient Signature:	**Date:**
Parent/Guardian Signature:	**Date:**
Provider Signature:	**Date:**

Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials:	Reviewed Date: Initials:

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