

Your Practice Name Here

TRANSITION MEDICAL SUMMARY/ADULT HEALTH CARE PLAN

Name:

Birth date:

Chronic health conditions:

Pertinent medical history:

Pertinent test results:

Surgeries/Procedures:

Hospitalizations:

Current medications:

Allergies:

Vision:

Hearing:

Immunizations:

Nutrition and growth:

Toileting:

Puberty:

Current Health Care Providers (most recent visits, with notes enclosed if available, and planned follow up):

Primary care:

Neurologist:

Dentist:

Ophthalmologist:

Other specialist:

Insurance:

Equipment/Supplies:

Education:

Psychoeducational evaluations:

Driving:

Guardian(s) (if applicable):

Pertinent personal/social characteristics:

ADULT HEALTH CARE PLAN:

1. Routine health care maintenance with primary care provider with yearly physical examinations and gynecological examinations for women and other health maintenance as recommended.
2. Immunizations as recommended, including a flu shot every fall and a tetanus shot every ten years.
3. Dental cleanings and check ups every six months.
4. It will be important to investigate insurance options available once no longer eligible for current plan.

Suggested specialty health care plan based on specific medical condition(s):

1. Follow up as planned with speciality care providers.
2. Follow health care guidelines for specific condition, enclosed if available.
3. Other as appropriate.

Health Care Provider Signature

Date created/updated

Cc: Patient