Coordinated Care Clinic
617-643-0606

Pediatric Medical Summary Form

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name:	Nickname:	Birthdate:
Home Address:	MGH Medical Record Number:	
Parent/Guardian(s):	Telephone Number(s):	
Email address:	Emergency Contact Names/Relationship:	
Primary Language:	Contact Telephone Number(s):	

Medical Providers:		Community Supports:	
Primary Care Provider:	Tel:	School:	Tel:
	Fax:	Social Worker:	Tel:
Specialty provider:	Tel:	Other supports (VNA, Early Intervention, DMR, etc. [enter names]):	
Specialty:	Fax:	:	Tel:
Specialty provider:	Tel:	:	Tel:
Specialty:	Fax:	:	Tel:
Specialty provider:	Tel:	:	Tel:
Specialty:	Fax:	:	Tel:
Specialty provider:	Tel:	Preferred Emergency Dept:	
Specialty:	Fax:	Tel:	
Specialty provider:	Tel:	Preferred Hospital:	
Specialty:	Fax:	Tel:	
Specialty provider:	Tel:	Preferred Pharmacy:	
Specialty:	Fax:	Tel:	

Diagnoses/Past Procedures:	Baseline Data:
1.	Baseline physical findings/mental status:
2.	
3.	Baseline vital signs:
4.	Other baseline findings (labs, x-ray, EKG):

Diagnoses/Past Procedures, continued:	Medications (type, dose, times of delivery):	
5.	1.	
	2.	
6.	3.	
	4.	
7.	5.	
	6.	
8.	7.	
	8.	
9.	9.	
	10.	
10.	11.	
	12.	
11.	13.	
	Prostheses/Appliances/Devices:	
12.	1.	2.
	3.	4.

ALLERGIES & things to be avoided and WHY:	Dietary considerations:
1.	1.
2.	2.
3.	3.

Common Presenting Problems and Specific Suggested Management:		
Problem	Suggested Diagnostic Studies	Treatment Considerations

Other things you should know (likes, dislikes, strengths, difficulties, what upsets/calms me):	
Parent Signature/Release*:	Physician/Provider Signature:
Print Name:	Print Name:

Adapted from the EIF For Children with Special Needs, American College of Emergency Physicians and American Academy of Pediatrics. Permission to reprint granted with acknowledgement.

*consent for release of this form to healthcare providers