Family Care Manual

FORMS

Missouri Department of Health and Senior Services
Special Health Care Needs

Individual/Family Information

- Individual's Name:_________________________________ Nickname: ________________

  Date of Birth:___________________ Social Security Number: ______________________

  Diagnosis:____

  Blood Type: ____

  Legal Guardian:____

  Address: ____

  Phone Number: ____

Family Members

- Mother's Name: ____

  Social Security Number:____

  Address: ____

  Daytime Phone:________________________ Evening Phone: ______________________
- Father's Name:____

  Social Security Number:____

  Address: ____

  Daytime Phone:________________________ Evening Phone: ______________________
- Sibling's Name:___________________ Age:____ Name:__________________ Age: _____
- Sibling's Name:___________________ Age:____ Name:__________________ Age: _____
- Other Household Members:____
- Important Family Information: ____

  ____

  ____
- Language Spoken at Home:____

  Other Language(s): ____

  Interpreter Needed? Yes:_________ No:_________

  Interpreter:_______________________________ Evening Phone: ___________________

Emergency Contact

- Name:____

  Address: ____

  Daytime Phone:________________________ Evening Phone: ______________________

Equipment/Supplies

- Name of Equipment: ____

  Description (brand name, size, etc.): ________________________________

  ____

  Date Obtained: __________ Supplier: _________________________________

  Contact Person: ____________________________ Phone: _______________

- Name of Equipment: ____

  Description (brand name, size, etc.): ________________________________

  ____

  Date Obtained: __________ Supplier: _________________________________

  Contact Person: ____________________________ Phone: _______________

- Name of Equipment: ____

  Description (brand name, size, etc.): ________________________________

  ____

  Date Obtained: __________ Supplier: _________________________________

  Contact Person: ____________________________ Phone: _______________

- Name of Equipment: ____

  Description (brand name, size, etc.): ________________________________

  ____

  Date Obtained: __________ Supplier: _________________________________

  Contact Person: ____________________________ Phone: _______________

- Name of Equipment: ____

  Description (brand name, size, etc.): ________________________________

  ____

  Date Obtained: __________ Supplier: _________________________________

  Contact Person: ____________________________ Phone: _______________

Insurance and Benefit Information

- Insurance Name: ____________________

  Policy Number: ____________________

  Contact Person/Title: ____________________

  Address: ____________________

  ____

  Phone: ____________________ Fax: ____________________

- Insurance Name: ____________________

  Policy Number: ____________________

  Contact Person/Title: ____________________

  Address: ____________________

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  Phone: ____________________ Fax: ____________________

- Healthy Options (Managed Care) Health Plan: ____________________

  Number: ____________________

  Contact Person/Title: ____________________

  Address: ____________________

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  Phone: ____________________ Fax: ____________________

- Children with Special Health Care Needs (CSHCN): ____________________

  Contact Person/Title: ____________________

  Address: ____________________

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  Phone: ____________________ Fax: ____________________

- Supplemental Security Income (SSI): ____________________

  Contact Person/Title: ____________________

  Address: ____________________

  ____

  Phone: ____________________ Fax: ____________________

- Other: ____

  Contact Person/Title: ______________________________________

  Address: ____

  ____

  Phone: ______________________ Fax: ____________________

Date	Procedure	Result	Comments

Allergies:____

Pharmacy: ____**Phone:**_____________________________

Date Started	Date Stopped	Medication	Dose/Route	Time Given	Prescribed By

Hospital Stay Tracking Form

DATE	HOSPITAL	REASON	NOTES

Date	Test	Result	Comments

Diet Tracking Form

DATE	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Tube Feeding							
Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

Growth Tracking Form

Date	Height	Weight	Head Circumference	Checked By

Care Schedule

TIME	CARE
Morning	
Afternoon	

Evening	
Night	

Log of Phone Numbers

Name:______________________________ Address:____________________________ ___________________________________ Phone:______________________________	Notes:

Name:______________________________ Address:____________________________ ___________________________________ Phone:______________________________	Notes:

Name:______________________________ Address:____________________________ ___________________________________ Phone:______________________________	Notes:

Name:______________________________ Address:____________________________ ___________________________________ Phone:______________________________	Notes:

Name:____________________ Address:____________________ ____________________ Phone:____________________	Notes:

Name:____________________ Address:____________________ ____________________ Phone:____________________	Notes:

Name:____________________ Address:____________________ ____________________ Phone:____________________	Notes:

Name:____________________ Address:____________________ ____________________ Phone:____________________	Notes:

MAKE-A-CALENDAR **MONTH____________________ YEAR_____________**

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Appointment Log

DATE	Provider	Reason Seen/Care Provided	Next Appointment

Infant and Toddler Preventive Services (0 – 3)

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
Newborn	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Hepatitis B (#1)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Sleep Positioning Counseling o Nutrition Counseling			
1 month	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Hereditary/Metabolic Screening			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
	Immunization o Hepatitis B (#2)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Sleep Positioning Counseling o Nutrition Counseling			
2 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Diptheria, Tetanus, Pertussis (DTaP) o Haemophilus influenzae Type b (Hib) o Inactivated Polio (IPV) o Pneumococcal Conjugate Vaccine (PCV)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Sleep Positioning Counseling o Nutrition Counseling			
4 months	History			
	Height			
	Weight			
	Head Circumference			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Diptheria, Tetanus, Pertussis (DTaP) o Haemophilus influenzae Type b (Hib) o Inactivated Polio (IPV) o Pneumococcal Conjugate Vaccine (PCV)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Sleep Positioning Counseling o Nutrition Counseling			
6 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
	Immunization o Hepatitis B (#3) o Diptheria, Tetanus, Pertussis (DTaP) o Haemophilus influenzae Type b (Hib) o Inactivated Polio (IPV) (between ages 6-18 months) o Pneumococcal Conjugate Vaccine (PCV) o Influenza (yearly)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Sleep Positioning Counseling o Nutrition Counseling			
9 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Inactivated Polio (IPV) (between ages 6-18 months)			
	Hematocrit or Hemoglobin			
	Lead Screening (if at risk)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Nutrition Counseling			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
12 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Haemophilus influenzae Type b (Hib) (between ages 12-15 months) o Inactivated Polio (IPV) (between ages 6-18 months) o Measles, Mumps, Rubella (#1) (MMR) (between ages 12-15 months) o Varicella (between ages 12-18 months) o Pneumococcal Conjugate Vaccine (PCV) (between ages 12-15 months)			
	Tuberculin Test (if at risk)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Nutrition Counseling			
	Dental Examination (if high risk)			
15 months	History			
	Height			
	Weight			
	Head Circumference			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Diptheria, Tetanus, Pertussis (DTaP) (between ages 15-18 months) o Haemophilus influenzae Type b (Hib) (between ages 12-15 months) o Inactivated Polio (IPV) (between ages 6-18 months) o Measles, Mumps, Rubella (#1) (MMR) (between ages 12-15 months) o Varicella (between ages 12-18 months) o Pneumococcal Conjugate Vaccine (PCV) (between ages 12-15 months)			
	Hematocrit or Hemoglobin (if at risk)			
	Tuberculin Test (if at risk)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Nutrition Counseling			
18 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			

Recommended Schedule	Exam/Screening/Vaccine	Date	Results	Doctor/Clinic
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Diptheria, Tetanus, Pertussis (DTaP) (between ages 15-18 months) o Inactivated Polio (IPV) (between ages 6-18 months) o Varicella (between ages 12-18 months) o Influenza (yearly)			
	Tuberculin Test (if at risk)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Nutrition Counseling			
24 months	History			
	Height			
	Weight			
	Head Circumference			
	Vision			
	Hearing			
	Developmental / Behavioral Assessment			
	Physical Examination			
	Immunization o Hepatitis A			
	Tuberculin Test (if at risk)			
	Anticipatory Guidance o Injury Prevention o Violence Prevention o Nutrition Counseling			

Children Preventive Services (3 – 13)

Screening

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Height/Weight	Annually – Age 3			
	Age 4			
	Age 5			
	Age 6			
	Age 7			
	Age 8			
	Age 9			
	Age 10			
	Age 11			
	Age 12			
Blood Pressure	Every 2 years – Age 3			
	Age 5			
	Age 7			
	Age 9			
	Age 11			
Cholesterol	Annually (if there is a family history) – Age 3			
	Age 4			
	Age 5			
	Age 6			
	Age 7			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Cholesterol (continued)	Age 8			
	Age 9			
	Age 10			
	Age 11			
	Age 12			
Hepatitis C	Annually (if in contact with someone in household who has tested positive or has a history of IV drug use) – Age 3			
	Age 4			
	Age 5			
	Age 6			
	Age 7			
	Age 8			
	Age 9			
	Age 10			
	Age 11			
	Age 12			
Vision	Every 2 yrs after first screening (if problems are suspected) – Age 3			
	Age 5			
	Age 7			
	Age 9			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Vision (continued)	Age 11			
Hearing	Age 4			
	Age 12			
Lead	Annually (if residence is in a high lead level area) – Age 3			
	Age 4			
	Age 5			
	Age 6			
	Age 7			
	Age 8			
	Age9			
	Age 10			
	Age 11			
	Age 12			
Chlamydia	Annually for all sexually active individuals – Age 11			
	Age 12			
Pre-Cancer	Annually – Age 3			
	Age 4			
	Age 5			
	Age 6			
	Age 7			
	Age 8			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Pre-Cancer (continued)	Age9			
	Age 10			
	Age 11			
	Age 12			
Other				

Immunization

Vaccine	Recommended Schedule	Date	Doctor/Clinic
Hepatitis A	One immunization between ages 2 & 17		
Hepatitis B (if not received between 0 – 3; catch up schedule)	One immunization between ages 4 & 6 years		
	1 – 2 mos. after initial immunization 6 mos. after second immunization		
Diptheria, Tetanus, Pertussis	One immunization between ages 4 & 6		
Inactivated Polio	One immunization between 4 & 6		
Varicella	Once for older children without history of chicken pox or chicken pox immunization (If not given between 12 & 18 months)		
Measles, Mumps, Rubella (MMR)	Between ages 4 & 6		
	2nd dose between ages 11 & 12 if not previously received		
Influenza	Annually (if certain risk factors are present) – age 3		
	Age 4		
	Age 5		
	Age 6		
	Age 7		

Vaccine	Recommended Schedule	Date	Doctor/Clinic
Influenza (continued)	Age 8		
	Age 9		
	Age 10		
	Age 11		
	Age 12		
Other			

Well Checks

Exam	Recommended Schedule	Date	Doctor/Clinic
Dental Exam	Every 6 months – Age 3		
	Age 3 1/2		
	Age 4		
	Age 4 1/2		
	Age 5		
	Age 5 1/2		
	Age 6		
	Age 6 1/2		
	Age 7		
	Age 71/2		
	Age 8		
	Age 8 1/2		
	Age 9		
	Age 9 ½		
	Age 10		
	Age 10 1/2		
	Age 11		
	Age 11 ½		
	Age 12		
	Age 12 1/2		

Exam	Recommended Schedule	Date	Results	Doctor/Clinic
Well Person Exam Female - clinical breast exam, pap (if sexually active) Male – testicular	Annually – Age 11			
	12 years			
Other				

Adolescent and Youth Preventive Services (13 – 21)

Screening

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Height/Weight	Annually – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Blood Pressure	Annually – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Vision	Every two years - Age 13			
	Age 15			
	Age 17			
	Age 19			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Cholesterol	Annually (if there is a family history) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Hepatitis C	Annually (if in contact with someone in household who has tested positive or has a history of IV drug use) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Hearing	Annually (or as needed if suspected of a hearing problem) – Age 13			
	Age 14			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Hearing (continued)	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Lead	Annually (if residence is in a high lead level area) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Chlamydia	Annually (for sexually active individuals) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
Chlamydia (continued)	Age 20			
Scoliosis	Annually (if at risk) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
Pre-Cancer	Annually – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			
	Age 18			
	Age 19			
	Age 20			
HIV	Annually (for sexually active individuals) – Age 13			
	Age 14			
	Age 15			
	Age 16			
	Age 17			

Screening	Recommended Schedule	Date	Results	Doctor/Clinic
HIV (continued)	Age 18			
	Age 19			
	Age 20			
Other				

Immunization

Vaccine	Recommended Schedule	Date	Doctor/Clinic
Hepatitis A	One immunization before age 17		
	Six months after 1st immunization		
Hepatitis B	One immunization recommended (if not previously immunized)		
	One month after 1st immunization		
	Six months after 2nd immunization		
Diptheria, Tetanus, Pertussis	Booster recommended between ages 13 & 16		
Influenza	Annually (if certain risk factors are present) – Age 13		
	Age 14		
	Age 15		
	Age 16		
	Age 17		
	Age 18		
	age 19		
	Age 20		
Vaccination History	Recommended for females in anticipation of pregnancy		

Vaccine	Recommended Schedule	Date	Doctor/Clinic
Multivitamins with Folic Acid	Recommended for females in anticipation of pregnancy		
Rubella	Recommended once after age 12 (females who are not pregnant)		
Other			

Well Checks

Exam	Recommended Schedule	Date	Results	Doctor/Clinic
Dental Exam	Every 6 months – Age 13			
	Age 13 ½			
	Age 14			
	Age 14 ½			
	Age 15			
	Age 15 ½			
	Age 16			
	Age 16 ½			
	Age 17			
	Age 17 ½			
	Age 18			
	Age 18 ½			
	Age 19			
	Age 19 ½			
	Age 20			
	Age 20 1/2			
Well Person Exam Female - clinical breast exam, pap (if sexually active) Male – testicular	Annually – Age 13			
	Age 14			
	Age 15			
	Age 16			

Exam	Recommended Schedule	Date	Results	Doctor/Clinic
Well Person Exam (continued)	Age 17			
	Age 18			
	Age 19			
	Age 20			
Other				

Adult Preventive Services (21 – 65)

Screening

Screening	Recommended Schedule	Date	Doctor/Clinic
Height/Weight	Annually (or as needed)		
Blood Pressure	Annually (or as needed)		
Total Blood Cholesterol	Annually (or as needed)		
Fecal Occult Blood Test	Annually (beginning at age 50)		
Chlamydia	Routine screenings recommended for all sexually active individuals		
Colonoscopy	Every 3 – 5 years beginning at age 50 or more frequent if at risk		
Hepatitis C	Annually (if in contact with someone in household who has tested positive or has a history of IV drug use)		
Pre-Cancer (monthly self breast exams, mammograms* & pap-female (monthly self testicular exams & prostate*-male)	Annually (*earlier than age 40 if there is a family history)		
Vision	Annually		
Other			

Immunization

Vaccine	Recommended Schedule	Date	Doctor/Clinic
Hepatitis A	One immunization before age 17		
	Six months after 1st immunization		
Hepatitis B	If not previously immunized, one at next visit		
	One month later		
	Six months later		
Influenza	Annually beginning at age 50		
Pneumococcal	One time to all persons whose immune systems have not been compromised		
Td	Boosters every 10 years or as recommended		
Vaccination History	Females in anticipation of pregnancy		
Multivitamins with Folic Acid	Females in anticipation of pregnancy		
Discuss hormone replacement therapy	Annually for peri- and postmenopausal females		
Other			

Well Checks

Exam	Recommended Schedule	Date	Doctor/Clinic
Dental Exam	Every 6 months		
Well Person Exam	Every 1 – 3 years if sexually active		
Female - pap	Annually		
mammogram	Every 1 – 2 years in sexually active females who have not had a hysterectomy (beginning at age 40)		
clinical breast exam	Annually		
Male – testicular and prostate cancer screen	Annually (beginning at age 40)		
Other			

Questions for the Doctor

1. ______________________________
2. ______________________________
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