Integrated Services Care Plan

Name ______________________

Birth Date ______________ ______ Male ______ Female

Address ______________________

______________ Phone ______________

Parent / Guardian ______________________

Address: ______________________

______________ Alternate Phone ______________

Member Lives with ______________________

Address ______________ Phone ______________

Supervisory Agency ______________________

Contact / Phone ______________________

Principal Coordinating Doctor – PCD

____

Address ______________________

____

Phone ______________ Fax ______________

Care Coordinator-

____

Address ______________________

Phone ______________ Fax ______________

Integrated Services Care Plan

______________ ______________

Medicaid ______________ County ______________

______________ ______________

Primary Insurance ______________ Phone ______________

Policy Holder ______________ ID ______________

Secondary Insurance ______________ Phone ______________

Policy Holder ______________ ID ______________

Dental Insurance ______________ Phone ______________

Policy Holder ______________ ID ______________

Vision Insurance ______________ Phone ______________

Policy Holder ______________ ID ______________

Care Coordinator

____

Phone ______________ Fax ______________

Qualifying Diagnosis	Other Diagnosis
1 ______________	1 ______________
2 ______________	2 ______________
3 ______________	3 ______________
4 ______________	4 ______________
5 ______________	5 ______________

For after hours advice please call your doctor. In a medical emergency call 911 or go to the nearest emergency room.

Copyright http://www.waisman.wisc.edu/~rowley/careplans/Downloads/IntegratedCarePlan.pdf.

SAMPLE

I. Current Problems with Status Summary

* Brief/Detailed narrative identifying mobility, ADL, cognitive ability, level of disease process and coping

II. Routine Health Maintenance

A. Well Care

Pediatrician / Family Doctor ______________________

Immunization Status – Up to Date - YES NO DUE **Include copy of record**

Address ______________________

Phone ______________ Fax ______________

Hospital Affiliation ______________________

Treatment Plan and Goals ______________________

B. Dental Care

General Dentist ______________________

Treatment Plan and Goals ______________________

Address ______________________

Phone ______________

Orthodontist ______________________

Treatment Plan and Goals ______________________

Address ______________________

Phone ______________

Member Name ______________ ID Number ______________

III. Specialty Care

C. Sub-Specialty Physicians

Clinic Name-Physician ____________________ Anticipated Number of Visits ________ Hospital Affiliation ________

Address ____________________ **Treatment Plan and Goals** ____________________

____________________ Phone ________ ____________________

Clinic Name-Physician ____________________ Anticipated Number of Visits ________ Hospital Affiliation ________

Address ____________________ **Treatment Plan and Goals** ____________________

____________________ Phone ________ ____________________

Clinic Name-Physician ____________________ ________ Hospital Affiliation ________

Address ____________________ **Treatment Plan and Goals** ____________________

____________________ Phone ________ ____________________

Clinic Name-Physician ____________________ ________ Hospital Affiliation ________

Address ____________________ **Treatment Plan and Goals** ____________________

____________________ Phone ________ ____________________

Clinic Name-Physician ____________________ ________ Hospital Affiliation ________

Clinic Name / Physician / Counselor Name ____________________ **Treatment Plan and Goals** ____________________

Address ____________________ ____________________

____________________ Phone ________

Is the member currently receiving these services? YES NO ________ ________

Member Name ________________ ID Number ________________

IV. Medical Support Services

G. Vision and Hearing

* Authorization for new hearing aids will require further documentation from the audiologist prior to ordering the aids.

Audiologist ______________________

Address ______________________

______________________ Phone __________

Hearing Aid Provider ______________________

Address ______________________

______________________ Phone __________

Optometry Provider ______________________

Address ______________________

______________________ Phone __________

Anticipated Number of Visits _____ Date of last Audiogram-Include Copy _______

Treatment Plan and Goals ______________________

____

Are new aids needed? YES NO Are new aids ordered? YES NO

Are new ear molds needed? YES NO Are new ear molds ordered? YES NO

Date of last new aids __________ Type of aids __________

Are new glasses needed? YES NO Are new glasses ordered? YES NO

Date of last new glasses __________ Date of last exam __________

Number of visits _____

H. Specialized Laboratory and Radiology

Lab / Radiology Facility ______________________

Address ______________________

______________________ Phone __________

Studies to be done ______________________

____

Ordering Physician ______________________

Lab / Radiology Facility ______________________

Address ______________________

______________________ Phone __________

Studies to be done ______________________

____

Ordering Physician ______________________

V. Hospital Care Inpatient / Outpatient

I. Scheduled Medical or Surgical Procedures

Clinic / Hospital ______________________

Procedure ______________________

Member Name __________ ID Number __________

Address ____________________

____________________ Phone ____________

Ordering Physician ____________________

Date Scheduled ____________

Clinic / Hospital ____________________

Address ____________________

____________________ Phone ____________

Procedure ____________________

Ordering Physician ____________________

Date Scheduled ____________

VI. Education

School Name ____________________

Address ____________________

____________________ Phone ____________

Contact Person

Child Care
Contact Person ____________________ Phone ____________

Date of last IEP/IFSP ____________ Date of next IEP/IFSP ____________

Classroom Type / Program ____________________

Early On Enrolled? YES NO Referred? YES NO Refused? YES NO

Date of last Child Assessment Form completion:

VII. Rehabilitation Services

J. Physical, Occupational and Speech Therapies

Physical Therapy Provider-School ____________________

Address ____________________

____________________ Phone ____________

Treatment Plan and Goals ____________________

____

Number of Visits ____________ Contact ____________

Physical Therapy Provider ____________________

Address ____________________

____________________ Phone ____________

Treatment Plan and Goals ____________________

____

Number of Visits ________ Contact ________

Occupational Therapy Provider-School ____________________

Address ____________________

Treatment Plan and Goals ____________________

____

Phone ________ | Number of Visits ________ Contact ________

Occupational Therapy Provider ________ | **Treatment Plan and Goals** ________

Address ________

Phone ________ | Number of Visits ________ Contact ________

Speech Therapy Provider-School ________ | **Treatment Plan and Goals** ________

Address ________

Phone ________ | Number of Visits ________ Contact ________

Speech Therapy Provider ________ | **Treatment Plan and Goals** ________

Address ________

Phone ________ | Number of Visits ________ Contact ________

Other Rehab Provider ________ | **Treatment Plan and Goals** ________

Address ________ Phone ________ | Number of Visits ________ Contact ________

VIII. Pharmacy Needs

K. All Medications

Medication and dose	Ordering Physician	Pharmacy Provider

Member Name ________ ID Number ________

L. Medical Supplies obtained from the Pharmacy

Supplies | Ordering Physician | Pharmacy Provider

M. Oral Nutritional Supplements obtained from the Pharmacy

Supplement Name | Ordering Physician | Pharmacy Provider / WIC

IX. Medical Equipment

N. Durable Medical Equipment

* Authorization for all Durable Medical Equipment will require a copy of the Rx and letter of medical need from the specialist before ordering.

Equipment Owned ______

Equipment Needs - Ordered ______

Equipment Rented ______

Incontinence Supplies and Quantity ______

DME Provider / Incontinence ______

Are supplies currently on order with this provider? YES NO Date ordered ______

Address ______

______ Copy of Rx

Phone ______

Fax ______

DME Provider ______

Is equipment currently on order with this provider? YES NO Date ordered ______

Member Name ______ ID Number ______

Address ______________________ ___ Copy of Rx ___ Letter of Medical Need

______________________ Phone __________ Fax ______________

DME Provider ______________________ Is equipment currently on order with this provider? YES NO Date ordered ________

Address ______________________ ___ Copy of Rx ___ Letter of Medical Need

______________________ Phone __________ Fax ______________

O. Orthotics and Prosthetics

***Authorization for new Orthotics or Prosthetics will require a copy of the Rx and possibly a letter of medical need before ordering.**

O & P Provider ______________________ Is there anything currently on order with this provider? YES NO Date ordered ________

Address ______________________ ___ Copy of Rx ___ Letter of Medical Need

______________________ Phone __________ Fax ______________

O & P Provider ______________________ Is there anything currently on order with this provider? YES NO Date ordered ________

Address ______________________ ___ Copy of Rx ___ Letter of Medical Need

______________________ Phone __________ Fax ______________

X. Home Health Care Infusion Supplies

Home Infusion Provider – NUTRITION ______________________ Ordering Physician ______________________

Prescription-Enteral or Parenteral ______________________ Supplies / Equip used ______________________

Address ______________________ ______________________

______________________ Phone __________ Estimated Length of Treatment __________

Home Infusion Provider – IV THERAPY ______________________ Ordering Physician ______________________

Prescription ______________________ Supplies / Equip used ______________________

Address ______________________ ______________________

______________________ Phone __________ __________

Member Name ______________ ID Number ______________

XI. Other Services

Social Services: (List)

Social Worker

Treatment Plan and Goals

:

Plan in place __Y __N __N/A

Transition Services

OVR Counselor: ______ Phone ______

Chiropractic Services

Clinic Name / Provider ______

Treatment Plan and Goals ______

Address ______

Phone ______

Transportation Services

Provider ______

Address ______ Phone ______

Contact person ______

XII. Nursing

Skilled Nursing Visits

Agency Name ______

Indication ______

Address ______

Treatment Plan and Goals ______

Phone ______

______ RN ______ LPN ______ AID

Ordering Physician ______

Hourly Nursing

Agency Name ______

Indication ______

Member Name ______ ID Number ______

Address ______________________________

______________________________ Phone ______________

Ordering Physician ______________________________

Treatment Plan and Goals ______________________________

______________________________ ______ RN ______ LPN ______ AID

____

Respite Care

Agency Name ______________________________

Address ______________________________

______________________________ Phone ______________

Ordering Physician ______________________________

Indication ______________________________

Treatment Plan ______________________________

______________________________ ______ RN ______ LPN ______ AID

____

Hospice Care

Agency Name ______________________________

Address ______________________________

______________________________ Phone ______________

Ordering Physician ______________________________

Indication ______________________________

Treatment Plan ______________________________

______________________________ ______ RN ______ LPN ______ AID

____

Community Services/ Referrals

Name

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Member Name ______________________ ID Number ______________________

XIII. Signature Page

I have actively participated in the development of this Integrated Care Plan. All the items and procedures have been explained to me. My questions have been answered. I understand and agree with the services described in this plan. I know that I can request additional services be added to this care plan.

Parent / Legal Guardian____ Date Agreed____________________

Care Coordinator____ Date Completed____________________

Principal Coordinating Doctor____ Date Reviewed/Agreed____________________

Print Name ____________________ Tax ID number ____________________ Physician Organization ____________________
(If Applicable)