

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE **COMMUNITY HEALTH NURSING (CHN) SPECIAL NEEDS RESOURCE COORDINATION -- CHILD AND YOUTH SERVICE PROGRAM**

OTSG APPROVED (Date)

PART I - SUBJECTIVE

1. Current or desired placement

- Child Development Center
- Family Care Center
- School Age Services
- Middle Age Services
- Teen Center
- Other:

2. Medication allergies

3. Current prescribed medications, over-the-counter medications, herbals, and dietary supplements

4. Cultural/religious needs

5. Special medical and/or educational needs

PART II - OBJECTIVE (item 6)

a. Parent(s) or guardian(s) present for the Special Needs Resource Team (SNRT) meeting. Yes No

b. Other:

PART III - ASSESSMENT (item 7)

Potential knowledge deficit related to services available to meet the child's needs.

PART IV - PLAN / INTERVENTIONS

8. CHN served as health consultant to SNRT
 Yes No

9. Parent(s) or guardian(s) discussed child's needs with/for SNRT
 Yes No

10. Medical records reviewed
 Yes No (unavailable)

11. Diagnosis was confirmed by Individualized Education Plan and/or Individualized Family Services Plan Yes No (unavailable) N/A

12. Special needs training to be arranged under the provisions of AR 608-10 (Child Development Services) Yes No

13. Exceptional Family Member Program status

14. Other

15. Parent(s) or guardian(s) was/were encouraged to contact CHN as needed. Yes No

16. The parent(s) or guardian(s) verbalized understanding of the information provided and agrees with plan of care. Yes No

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

Name:

DOB:

FMP/SSN:

Gender:

- HISTORY/PHYSICAL
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT
- FLOW CHART
- OTHER (Specify)