Project Access

Patient Coordinated Care Plan

Information Section

Patient Name			Date	
DOB		Sex □ M □	F	Language
Caregiver 1/Emergency C	ontact N	lame		
Address			C/S/Z	
Phone (H)	Work		Cell	Email
Caregiver 2/Emergency C	ontact N	lame		
Address			C/S/Z	
Phone (H)	Work		Cell	Email
Primary Care Physician				
Address			C/S/Z	
Phone (O)		Fax		Email
Epileptologist/Neurologis	st			
Address			C/S/Z	
Phone (O)		Fax		Email
Pharmacy				
Address			C/S/Z	
Phone (O)		Fax		Email
School				
Nurse			Teacher	
Address			C/S/Z	
Phone (N)		Phone (T)		Email
☐ Psychologist ☐ SW 〔	Couns	selor		
Address			C/S/Z	
Phone (O)		Fax		Email
Dentist				
Address			C/S/Z	
Phone (O)		Fax		Email
Epilepsy Case Manager			Agency	
Address			C/S/Z	
Phone (O)		Fax		Email
CMS Nurse/Case Manage	er			
Address			C/S/Z	
Phone (O)		Fax		Email
List Allergies				
Seizure Information				

☐ Simple Partial	☐ C	omplex Par	tial	☐ Seconda	•	☐ Abs	ence	Generalized Tonic-
				Generalized				Clonic
☐ Myoclonic	☐ CI	onic		☐ Atonic		☐ Juve	enile Myocloni	c Childhood Absence
☐ Lennox-Gastaut	☐ Fe	ebrile Seizu	ires	Benign F	Rolandic	☐ Tub	erous Sclerosi	Non-Classified
Usual Len	gth			Frequ	iency			Description
Date First Seizure			Date I	Last Seizure	9		Date of Di	agnosis
Device Type		Model			Serial #		D	ate Implanted
Dietary Therapy			Date B	egun			Special Instr	uctions

Patient Name			Date			
Possible seizure triggers						
Does patient need any special a	activity ada	ptations/protective e	quipment (e.g., helme	t) at school	? 🛮 No 🗖	Yes (explain)
			2 🗖 N. 🗆	1 1 1		\
Is patient allowed to participat	e in physica	al education and other	ractivities? 🗀 No 🗅	Yes (expla	ain special p	orecautions)
Challenges (Check ALL th	hat annly	and evolain helov	w).			
☐ Behavior ☐ Learning		•	•	☐ Respirato	ory 🖵 Ort	hopedic 🗖 Autism
☐ Mental Health ☐ Hearing/	Vision 🚨	Physical Anomalies	☐ Sensory ☐	Other:		·
Explain:						
Seizure Medication Infor	mation (For additional info	ormation, see atta	ched list	of medic	ations)
Are medications needed	to contro	I the patient's sei	zures? 🗆 No 📮	Yes (If ye	es, list me	edications.)
Medications: 🗖 Ativan 🗖 Ba		•				•
🗖 Felbatrol 🗖 Gabitril 🗖 Ke	eppra 🗖 K	eppra XR 🛭 Klonopir	☐ Lamictal ☐ Lyric	a 🛭 Myso	line □Neເ	ırontin
☐ Vigabatrin ☐ Phenobarbita						xene 🖵 Trileptal
☐ Vimpat ☐ Zarontin ☐ Zor					Other:	
Medication Name		Amount Taken	How Often	Beginni	ng Date	End Date
Does Patient need medication	or device a	dministered at school	? ☐ No ☐ Yes (If ye	es, complet	e the next s	section.)
Medication/Device Name	Amount	to Give	When to Give		How to 0	Give
Shunt setting						
Baclofen Pump						
G-Tube						
Possible side offects that	must ha	reported to paren	t or physician:			
Possible side effects that	must be	reported to paren	t or physician:			
			C	C		Data
Surg	geries		Surgeon/Place of	Surgery		Date
			<u> </u>			
					I	

Patient Name		Date		
Community Resource Informati				
Some Resources (check all that a	1 1 //			
☐ Schools: ☐ Special Education ☐ 45		e of School:		
Other Resources (check all that a				
☐ SSI ☐ Waiver Program ☐ CMS ☐				
Early InterventionHome Health (Other:	Care	nators u Respite u	Support Group 🗀 Seizure Tracker	
Does family need help with reso		Voc (Evolain)		
·				
Does family need respite care?	<u> </u>	•		
Does family have transportation				
Some Specialists	Phone #	Fax #	Frequency of Services	
PT Therapist:				
OT Therapist: ST Therapist:				
DT Therapist				
Other Case Mgr.				
Other Case Mgr.				
Other Case Mgr.				
Permission I give my permission to share the Epilepsy Foundation of Florida, t		•	· · · · · · · · · · · · · · · · · · ·	
Parent/Legal Guardian (Print Name Parent/Legal Guardian Signature: Date plan sent to providers Physican (Print Name):	e):	By whom:	Date:	
Physician Signature:			,	
Completed by:				

Patient Name