


Shared Care Plan for Children and Youth with Special Health Needs

Child/youth name:		Necessary releases obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child/youth likes to be called:		Team meeting date:	
Date of birth:		Meeting location:	
Parent(s):		Referred by:	
Parent phone #:			
Primary care provider:	Interpreter (if applicable):		
Gender identity: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other, please specify:			
Pronouns: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> Other, please specify:			

Child/Family Strengths and Assets

Child/Family Language and Culture

Child/Family Concerns and Goals
For today:
For the longer term:

Last Updated:

Brief Medical Summary	
Diagnosis:	
Medications:	
Current Interventions:	Tried Interventions:
Health Care Providers:	
Other Important Medical Information (Allergies/Alerts):	
Preferred Hospital:	Preferred Pharmacy:


Brief Summary of Involvement with Education/Community-Based Services

Team Members Contact List		<i>Note: Initial next to name to note attendance at meeting. Add rows as needed.</i>
Name	Role/Responsibility	Best way to contact
	Family member	
	Primary care provider	
	Education	
	Mental/behavioral health	
	Public health	
	Health plan/insurance	
	Interpreter	

Action Plan

Note: Add rows as needed.


- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.


Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date Date completed:
	This person	Will take this action	By this date Date completed:
	This person	Will take this action	By this date Date completed:
	This person	Will take this action	By this date Date completed:
Date identified:	Notes:		
Date resolved:			

Action Plan

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Action Plan			
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