

Client Name:

CSHCS ID #:

SOCIAL SUMMARY - REQUIRED		

THERAPIES (school/community/private)		
Name/Facility	Type of Therapy	Treatment Plan

MEDICAL PROVIDERS
Include current and list plans for upcoming year (i.e. frequency, treatment provided, procedures planned, etc)
Inpatient Facilities (i.e., hospitals):
Outpatient Facilities (i.e., labs):

Client Name:

CSHCS ID #:

List All Medical Providers		
Name, Address, Phone	Specialty / Hospital Affiliation	Frequency / Treatment Plan
	Primary Care Physician	Last Well Exam:
	Dentist	Last Exam:

Client Name:

CSHCS ID #:

ADDITIONAL MEDICAL PROVIDERS		
Name, Address, Phone	Specialty / Hospital Affiliation	Frequency / Treatment Plan

Pharmacy		
List all medications (Rx and OTC) & Route		
Equipment		
DME/IV Providers		

ADDITIONAL COMMENTS (optional)

SIGNATURE PAGE

Client Name: _____

CSHCS ID #: _____

SIGNATURES OF THOSE PARTICIPATING IN COMPLETION OF POC	
Parent/Guardian/Client:	Date:
Nurse:	Date:

If there are NO corrections to the PLAN OF CARE:

RETURN THIS PAGE ONLY

Otherwise return corrections and this page.