Healthcare Coordinator Quarterly Summary

Individual Receiving Services: _____ Date of Birth: _____

Report Period: From: ____ to: ____ Dates of face to face visits (if applicable): _____

In the last ISP quarter (three months) did any of the following occur?	Check Yes if it occurred.	Agency Nurse Comments
Health Care Provider Appointments/ Hospitalization Hospitalization If yes; Date: _____ Reason: _____ Routine medical appointments Unplanned medical appointments Emergency or Urgent care visits New Diagnosis: _____ Describe any concerns regarding results of above: _____	 Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐	
Medical/Lab tests All ordered tests were completed? If not, what is missing or scheduled, but not yet completed? _____ Results of medical/lab tests were given to the Service Coordinator?	 Yes☐ No☐ N/A ☐ Yes☐ No☐ N/A ☐	

In the last ISP quarter (three months) did changes/concerns occur in any of the following?	Check Yes for changes or concerns.	Agency Nurse Comments
General Health Activity (Circle the change: energy level, daily function, ability to perform self care, other _____.) Bowel/bladder movements - Difficulty breathing - Falls or Mobility - Pain - Seizures - Skin (Circle the change: color, cuts, rashes, sores, swelling) - - - - - - - - Sleep habits - Unexplained bleeding - Vision or hearing - Other _____ Describe what is being done to address any of above changes/concerns: _____	 Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐	
Behavior Behavior changes: _____ Describe what is being done to identify a possible medical cause: _____	 Yes☐ No☐	

Healthcare Coordinator Quarterly Summary

Individual Receiving Services: _____ Date of Birth: _____

In the last ISP quarter (three months) did changes/concerns occur in any of the following?	Check Yes for changes or concerns.	Agency Nurse Comments
Medication Changes (in either dosage or type of medication) Problems (For example: Individual often refuses to take medication, individual complains of side effects, etc.) Increased use of PRN (as needed) Medications Describe what is being done to address any problems or major changes: ____	Yes☐ No☐ Yes☐ No☐ Yes☐ No☐	
Nutrition Services Problems eating or swallowing New/Revised Mealtime plan Change in eating patterns/appetite Unintentional weight change of 10 pounds or more Describe what is being done about any concerns above: ____	Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐	

If the individual needs any of the following services, did changes/concerns arise this quarter?	Check Yes for changes or concerns.	Agency Nurse Comments
Specialty Services Medical supplies/equipment Therapies (Circle the therapy in concern: Physical Therapy, Occupational Therapy, Speech Therapy, Behavior Support Consult / other_____.) Access to Medical Specialist(s) besides PCP: (Insert specialist: _____.) Describe nature of Specialty Services concern: ____ What is being done to address: ____ Completed Request for Regional Office Intervention?	Yes☒ No☐ N/A ☐ Yes☐ No☐ N/A ☐ Yes☐ No☐ N/A ☐ Yes☒ No☐ N/A ☐ Yes☐ No☐ N/A ☐	

Describe other changes or concerns: ____

Has the guardian been notified of all changes and/or concerns? Yes☐ No☐
Has the agency nurse been notified of all changes and/or concerns? Yes☐ No☐
Is an IDT needed? Yes☐ No☐ Unsure☐

Completed by: _____

Relationship to Individual: _____ Date: _____