Pediatric Care Coordination “Assessment”

Child’s Name ____________________________________ Family Name ____________________________ Date ______________

1) What would you like us to know about your child?
   (What does he/she do well? Like? Dislike?)

2) What would you like us to know about you/your family?

3) Do you have any concerns or worries for your child? (Some examples below)
   ☐ Their growth/development  ☐ Doing things for themselves
   ☐ Learning  ☐ Falling behind in school
   ☐ Sleeping  ☐ Behavior
   ☐ Self-care  ☐ The future
   ☐ Making and keeping friends  ☐ Playing with friends
   ☐ Other (fill in): ________________________________

4) Have there been any changes in your family since we saw you last, such as a:
   ☐ Brother of sister leaving home?  ☐ New job or job change?
   ☐ Move to a new town?  ☐ Separation or divorce?
   ☐ Sickness or death of a loved one?  ☐ Other (fill in below)?

5) Can we help you with any of the following needs?
   ☐ Medical Needs (For example, help finding or understanding medical information; help finding health care for yourself or your family)?
   ☐ Social Needs (For example, having someone to talk to when you need to; getting support at home; finding supports for the rest of your family)?
   ☐ Educational Needs (For example, explaining your child’s needs to teachers; help reading or understanding medical information)?
   ☐ Financial Needs (For example, understanding insurance or finding help paying for needs that insurance does not cover - such as medications, formulas, or equipment)?
   ☐ Legal Needs (For example, discussing laws and legal rights about your child’s health care or their school needs)?

6) What do you want or need? (We will work with you to find answers if we can).
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