Welcome to Elite Primary Care Medical Home for the Family

(Parents handout)

Welcome to your Elite Primary Care Medical Home. A Medical Home is a trusting partnership between a doctor-led health care team and an informed patient and caregiver. As a family medicine practice, we provide quality health care for all ages to include teens and young adults.

Teens and young adults need specialized medical care and a doctor with whom they can discuss anything, from normal body growth and development, illness, preventive care, sexual concerns and emotional problems. Their parents also need special guidance and support through these years. Our practice goal is to provide comprehensive health care to our patients and their families.

Elite Primary Care is committed to helping our pediatric patients become better prepared for an adult model of health care at age 18 to continue on with our practice as young adults. At about age 14 we will begin to spend time during the visit without the parent present in order to answer questions, set health goals, and support increasing independence with health care. It is our practice to ask parents to wait outside for part of the interview and encourage the teen to discuss his or her own view of their problem. Talking to teens without the parent also gives teens a chance to ask questions or give information they may feel self-conscious about. Teens often have questions or concerns that they may feel embarrassed to talk about in front of their parents. Please review our teen transition packet together with your child. This will help prepare you both for this transition successfully.

Many teenagers and young adults experiment with high-risk behaviors that can lead to serious problems. Sometimes teenagers will hide their behavior so parents are not the first to find out. Our goal is to help prevent and identify these problems before they become serious.

Tennessee state law requires that some services are offered to teens privately. This includes pregnancy testing and services, contraception, testing for and treatment of sexually transmitted infections, substance abuse treatment, and mental health counseling. We ask parents to leave for part of the interview for confidentiality and to build trust. We also encourage the teen to discuss important issues with their parent or guardian.

It is important to know that if a teen is doing anything to hurt themselves or others, or if someone is hurting them, we will be forced to break confidentiality and tell an appropriate adult.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. However, we will no longer be allowed to discuss anything with parents about care or share any personal health information without the young adult's written consent. To allow others to be involved in health care decisions requires that a signed consent form be completed, which we have at the clinic. (also attached to this packet) If an adolescent has a condition that prevents him/her from making decisions, we encourage families to consider options for supported decision-making.

Your health is important to us. If you have any questions or concerns, please feel free to contact us. The staff is always available to discuss health problems or answer questions. Our staff wants to work with you to help your teen(s) make the best choices for a healthy future.

ELITE PRIMARY CARE

REGISTRATION FORM

Today's Date: ______________________________

Patient's last name:		First:			Middle:
Marital status:	Birth date:		Age:	Race:	
Ethnicity: * ○ Not Hispanic ○ Hispanic ○ Latin	Driver's License #:	Social Security #:	Sex: ○M ○F	Your Pharmacy/location:	

Address:		
Home phone:	Cell phone:	Email:
Occupation:	Employer:	Work phone:

Chose clinic because/referred to clinic by:

Other family members seen here:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Person responsible for bill: *(self or parent)*	Birth date:	Address (if different):	Phone:
Is this person a patient here?	● Yes ● No	Occupation/Employer:	Work phone:

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? *circle one:*

Medical info only *Appointment info only* *Both*

Person's Name: Relationship to patient:

Person's Name: Relationship to patient:

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access.

* (this does not apply to controlled substances) ○ I elect to OPT-OUT

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Elite Primary Care to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Elite Primary Care for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. Charges for the collection of delinquent accounts, including collection agency charges, court costs, and or reasonable attorney's fees will be added to the total balance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my provider, or any person employed by or under the direction and control of my provider, is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

______________________________ ______________

Patient/Guardian signature Date

Sample Transition Readiness Assessment

for Youth/Young Adults

Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health, using health care and areas that you need to learn more about. If you need help completing this form, please let us know.

Date:

Name: Date of Birth:

Transition and Self-Care Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it to you to manage your own health care?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to manage your own health care?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health *Please check the box that applies to you right now.*	*Yes, I know this*	*I need to learn*	*Someone needs to do this… Who?*
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and the medicines I should not take.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
I know or I can find my doctor's phone number.	☐	☐	☐
I make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know to I need to show up 15 minutes before the visit to check in.	☐	☐	☐
I know where to go to get medical care when the doctor's office is closed.	☐	☐	☐
I have a file at home for my medical information.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to get referrals to other providers.	☐	☐	☐
I know where my pharmacy is and how to refill my medicines.	☐	☐	☐
I know where to get blood work or x-rays done if my doctor orders them.	☐	☐	☐
I carry important health information with me every day. (e.g. insurance card, allergies, medications, emergency contact information, medical summary)	☐	☐	☐
I understand how health care privacy changes at age 18 when legally an adult.	☐	☐	☐
I have a plan so I can keep my health insurance after 18 or older.	☐	☐	☐
My family and I have discussed my ability to make my own health care decisions at age 18.	☐	☐	☐

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Sample Transition Readiness Assessment
for Parents/Caregivers
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what your child already knows about his or her health and the areas that you think he/she needs to learn more about. After you complete the form, compare your answers with the form your child has complete. Your answers may be different. We will help you work on some steps to increase your child's health care skills.

Date:

Name: Date of Birth:

Transition and Self-Care Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it for your child to manage his or her own health care?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your child's ability to manage his or her own health care?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health *Please check the box that applies to you right now.*	*Yes, he/she knows this*	*He/she needs to learn*	*Someone needs to do this… Who?*
My child knows his/her medical needs.	☐	☐	☐
My child can explain his/her medical needs to others.	☐	☐	☐
My child knows his/her symptoms including ones that he/she quickly needs to see a doctor for.	☐	☐	☐
My child knows what to do in case he/she has a medical emergency.	☐	☐	☐
My child knows his/her own medicines, what they are for, and when he/she needs to take them.	☐	☐	☐
My child knows his/her allergies to medicines and medicines he/she should not take.	☐	☐	☐
My child can explain to others how his/her customs and beliefs affect health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
My child knows or can find his/her doctor's phone number.	☐	☐	☐
My child makes his/her own doctor appointments.	☐	☐	☐
Before a visit, my child thinks about questions to ask.	☐	☐	☐
My child has a way to get to his/her doctor's office.	☐	☐	☐
My child knows to show up 15 minutes before the visit to check in.	☐	☐	☐
My child knows where to go to get medical care when the doctor's office is closed.	☐	☐	☐
My child has a file at home for his/her medical information.	☐	☐	☐
My child has a copy of his/her current plan of care.	☐	☐	☐
My child knows how to fill out medical forms.	☐	☐	☐
My child knows how to get referrals to other providers.	☐	☐	☐
My child knows where his/her pharmacy is and how to refill his/her medicines.	☐	☐	☐
My child knows where to get blood work or x-rays if his/her doctor orders them.	☐	☐	☐
My child carries important health information with him/her every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	☐	☐	☐
My child knows he/she can see a doctor alone as I wait in the waiting room.	☐	☐	☐
My child understands how health care privacy changes at age 18.	☐	☐	☐
My child has a plan to keep his/her health insurance after ages 18 or older.	☐	☐	☐
My child and I have discussed his/her ability to make his/her own health care decisions at age 18.	☐	☐	☐
My child and I have discussed a plan for supported decision-making, if needed.	☐	☐	☐

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Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

This document should be shared with and carried by the patient.		
Date Completed:	Date Revised:	
Form Completed By:		
Contact Information		
Name:	Nickname:	
DOB:	Preferred Language:	
Parent (Caregiver):	Relationship:	
Address:		
Cell #: Home #:	Best Time to Reach:	
E-Mail:	Best Way to Reach: Text Phone Email	
Health Insurance/Plan:	Group and ID #:	
Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		
Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Special Concerns for Disaster:		
Allergies and Procedures to be Avoided		
Allergies	Reactions	
To be avoided	Why?	
☐ Medical Procedures:		
☐ Medications:		
Diagnoses and Current Problems		
Problem	Details and Recommendations	
☐ Primary Diagnosis		
☐ Secondary Diagnosis		
☐ Behavioral		
☐ Communication		
☐ Feed & Swallowing		
☐ Hearing/Vision		
☐ Learning		
☐ Orthopedic/Musculoskeletal		
☐ Physical Anomalies		
☐ Respiratory		
☐ Sensory		
☐ Stamina/Fatigue		
☐ Other		

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Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

Medications

Medications	Dose	Frequency	Medications	Dose	Frequency

Health Care Providers

Provider	Primary and Specialty	Clinic or Hospital	Phone	Fax

Prior Surgeries, Procedures, and Hospitalizations

Date	
Date	
Date	
Date	
Date	

Baseline

Baseline Vital Signs: Ht Wt RR HR BP

Baseline Neurological Status:

Most Recent Labs and Radiology

Test	Date	Result
EEG		
EKG		
X-Ray		
C-Spine		
MRI/CT		
Other		
Other		

Equipment, Appliances, and Assistive Technology

☐ Gastrostomy	☐ Adaptive Seating		☐ Wheelchair
☐ Tracheostomy	☐ Communication Device		☐ Orthotics
☐ Suctions	Monitors:		☐ Crutches
☐ Nebulizer	☐ Apnea	☐ O2	☐ Walker
	☐ Cardiac	☐ Glucose	
☐ Other			

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Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

School and Community Information		
Agency/School	Contact Information	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

Special information that the patient wants health care professionals to know

Patient signature | Print Name | Phone Number | Date

Parent/Caregiver | Print Name | Phone Number | Date

Primary Care Provider Signature | Print Name | Phone Number | Date

Care Coordinator Signature | Print Name | Phone Number | Date

Please attach the immunization record to this form.

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