NEXT STEP

Delegate Name: _____

Next Step's FACE FORWARD Campference Physician Form

To be returned to Next Step by Friday, May 1st, 2020

Please fill out immediately and return to office. All applications are accepted in the order they are received.

Please note: ALL QUESTIONS MUST BE ANSWERED for an application to be considered COMPLETE.

Date and time received (office use only) _____

Patient Name: _____

DOB: _____ Date of Exam: _____

Height: _____ Weight: _____ BP: _____

Primary MEDICAL DIAGNOSIS: _____ Date of Diagnosis: _____

Please list Current Problems or Secondary Diagnosis: Comments

_____ _____

_____ _____

Describe any physical disability and/or physical limitations: _____

_____

Any activity limitations? Describe:

Drug Allergies: Reaction:

Food Allergies: Reaction:

Environmental Allergies (bee, latex, etc) Reaction:

NEXT STEP

Delegate Name: _____

Review of Systems: (Please CHECK ALL that apply):

ENT: ☐ Cataracts ☐ Hearing loss
☐ Blindness ☐ Deafness ☐ Other:_____

Resp: ☐ Asthma ☐ Apnea
☐ Pulmonary Embolus ☐ Oxygen requirement
☐ Pneumonia ☐ Other:_____

Cardiac: ☐ Murmur ☐ CHF
☐ HTN ☐ Pacemaker
☐ Hx Heart Attack ☐ Internal Defibrillator ☐ Other:_____

GI: ☐ Irritable Bowel ☐ Peptic Ulcers/Reflux
☐ Constipation ☐ Other:_____

GU: ☐ Kidney Infections ☐ UTI
☐ STD ☐ Bladder Dysfunction ☐ Other:_____
Neuro: ☐ CVA ☐ Seizure Disorder ☐ Migraine

Endo: ☐ Diabetes ☐ Growth Disorder ☐ Other:_____

Psychiatric: ☐ Anxiety ☐ Depression ☐ Panic Disorder
☐ Autism Spectrum ☐ Developmental Delay ☐ Post-traumatic Stress Disorder
☐ Bipolar Disorder ☐ Eating Disorder ☐ Schizophrenia/Psychotic Disorder

Assistive Devices: ☐ Wheelchair ☐ Walker ☐ Crutches ☐ Shower Chair

Assistance with ADL: ☐ Dressing ☐ Bathing ☐ Eating ☐ Toileting

Does patient have:

Central Venous Catheter ☐ Yes ☐ No
If yes, TYPE: ☐ External *(Broviac/Hickman)* ☐ Internal *(Portacath/Infusaport)* ☐ Other
G-tube/J-tube ☐ Yes ☐ No
Gastrostomy Feeding ☐ Yes ☐ No If Yes, please include orders on Medication List
TPN ☐ Yes ☐ No If Yes, please include orders on Medication List
IV or Subcutaneous Meds ☐ Yes ☐ No If Yes, please include orders on Medication List

Please list all surgeries and dates:

Date of last Hospitalization. Reason and LOS:

NEXT STEP

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All participants will bring all medications, catheter dressings and any other supplies necessary (heparin, saline, syringes, access needles, numbing spray/cream, etc.) for their care while at the campference. If heparin is required, please include amount, strength, and frequency on the Medication section below. Chemotherapy and blood work should be schedule before or after the participant plans to attend the Next Step Campference.

MEDICATIONS:

Complete Physician's order is required for **ALL** medications including OTC and PRN medications that will be administered at campference. Please attach list if more space is needed.

Name of Medicine	Dose	Route	Frequency

Is the participant currently compliant with their prescribed medication regimen? Please describe:

IMMUNIZATIONS: ***Please attach a copy of the patient's most recent immunization record.***

Please check the appropriate response:

TB Test Result: ☐ + ☐ -

Test Method: ☐ **PPD** ☐ **Blood Test**

Date of Test: _____

History of Chest X-Ray: _____

IMPORTANT!

Immunization Requirements* Include:

2 MMR (Measles, Mumps, Rubella)

2 Varicella (Chicken Pox)

Tdap Booster

**Unless medically exempt*

PHYSICIAN'S STATEMENT:

I have examined _____ and find him/her physically able to engage in campference activities, except for physical limitations and restrictions listed above. I understand the above medical regimen will be followed while the patient is at campference.

_____ _____ _____

Signature of Provider (Mandatory) Print Name Date (Mandatory)

Institution:_____ Address:_____

Phone numbers where a health professional who is familiar with this participant can be contacted while the participant is at campference:

Days:_____ Nights:_____ Weekends:_____

NEXT STEP

Delegate Name: _____

Psychosocial Risk Assessment

For Applicants who are currently receiving mental health services (psychiatric medication or therapy), this form MUST BE completed by their mental health provider/prescriber. Otherwise, this form should be completed by the assessing Physician.

Please CHECK (YES) or (NO) where applicable or CHECK the most applicable frequency

Has the applicant engaged in any self-harming behaviors within the last year? ☐ YES ☐ NO

Has the applicant experienced ideas about self-harm within the last 6 months? ☐ YES ☐ NO

Has the applicant ever attempted suicide? ☐ YES ☐ NO

Has the applicant experienced suicidal ideation within the last year? ☐ YES ☐ NO

Does the applicant have a history of violence towards others? ☐ YES ☐ NO

Does the applicant have a past history of drug or alcohol abuse/dependence? ☐ YES ☐ NO

How often does the applicant use alcohol? ☐ Never ☐ 1-2 month ☐ 1-2 week ☐ 3+ week

How often does the applicant use illicit drugs? ☐ Never ☐ 1-2 month ☐ 1-2 week ☐ 3+ week

Has the applicant received mental health services in the last year? ☐ YES ☐ NO
If yes, please indicate type of treatment and diagnosis, if applicable:

Is the participant currently experiencing any mental health symptoms ☐ YES ☐ NO
or intense emotions that are impairing functioning? If yes, please describe:

_____ _____ _____

Signature of Provider Print Name Date

_____

Title

NEXT STEP

Delegate Name: _____

Sickle Cell Anemia Form (*IF APPLICABLE*)

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Patient: _____ DOB:_____

What hemoglobinopathy does the patient have? (SS, SC, etc.) _____

What is patient's baseline room air oximetry?_____

What complications has patient had? _____

_____

	YES	NO	Comments/Date
Frequent VOC			
Acute Chest Syndrome			
Stroke			
AVN			
Priapism			
Splenic Sequestration			
Bacteremia/Infection			
Gallstones			

Does patient have splenomegaly? ☐ YES ☐ NO If Yes, spleen size_____

Is patient on a chronic transfusion protocol? ☐ YES ☐ NO

History of allo/auto antibodies? ☐ YES ☐ NO Details_____

History of transfusion reactions? ☐ YES ☐ NO Details_____

Please provide most recent or baseline labs: Date:_____

Hb _____ Hct _____ Retic _____ WBC_____ CXR_____ Other: _____

Pain Protocol:

Mild Pain: _____

Moderate (increasing) Pain: _____

Severe Pain: _____

Additional Information: _____

_____ _____ _____

Signature of Provider Print Name Date

NEXT STEP

Delegate Name: _____

Metabolic/Mitochondrial Form *(IF APPLICABLE)*

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Patient:_____ DOB:_____

Diagnosis: _____ Date of Diagnosis:_____

ACTIVITY LEVEL

What is patient's typical activity level? _____

How much time does he/she spend outside? _____

DIET/FLUIDS

How much fluid does the child need in a day? _____

Does patient need blood glucose checked? ☐ YES ☐ NO

If yes, Frequency and Schedule? _____

What dietary restrictions/requirements does patient have? _____

_____

MEDICAL EMERGENCIES – please attach a copy of patient's emergency protocol

What are the early signs the patient is decompensating?

What treatment should be provided?

What are the signs that his/her illness is progressing and that more aggressive treatment is needed?

What treatment should be provided?

When does patient need to go to the hospital?

_____ _____ _____

Signature of Provider Print Name Date