Medical information

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Health care providers

Primary care provider (PCP): _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Preferred hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Specialty hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Lab: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

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Specialists

Specialist: _____ Type: _____

Clinic/hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone:_____ Fax: _____ Email: _____

Specialist: _____ Type: _____

Clinic/hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone:_____ Fax: _____ Email: _____

Specialist: _____ Type: _____

Clinic/hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone:_____ Fax: _____ Email: _____

Specialist: _____ Type: _____

Clinic/hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone:_____ Fax: _____ Email: _____

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Additional contacts

Dentist: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Orthodontist: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Nutritionist/dietician: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Social worker/case manager: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Home health agency: _____

Start date:_____ End date:_____ Contact person:_____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Home health agency: _____

Start date: _____ End date: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Cook Children's

Pharmacy contacts

Pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Compounding pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Compounding pharmacy: _____ Contact person: _____

Address: _____ City: _____ State: ____ ZIP code: _____

Phone: _____ Fax: _____ Email: _____

Cook Children's

Other contacts

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

Name:_____

Address:_____City:_____State:___ ZIP code:_____

Phone: _____ Fax: _____ Email: _____

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Helpful hint: Use this page to write down notes from telephone calls, office visits or any other conversations about your child's health care.

Communication notes

Date: _____ Time: _____

Communication type (telephone, meeting, email, other): _____

Name: _____ Title: _____

Agency: _____ Phone: _____

Address: _____

Reason:

Discussion:

Summary:

Follow-up:

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Growth chart

Child's name: _____Date of birth:_____

Date measured	Age	Weight	Height (length)	Percentiles			Comments
				Weight/age	Height/age	Weight/height	

What is a percentile?

A percentile shows how your child's height and weight compares to other children of the same age and sex. Height and weight are measured separately.

Example: If your son is in the 30th percentile for weight, this means that 30 percent (or 30 out of 100) boys the same age weigh the same or less. This also means that 70 percent (or 70 out of 100) boys weigh more.

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Helpful hint: Ask your child's primary care provider (PCP) for a copy of your child's vaccine (shot) record.

Immunizations (vaccinations)

Be sure your child's immunizations are up to date.

	Date	Date	Date	Date	Date	Date	Date	Date	Provider signature
HepB (Hepatitis B)									
DTaP (Diptheria Tetanus and Whooping Cough)									
Haemophilus influenzae type b									
Polio (IPV)									
PVC13 (Pneumococcal Conjugate)									
RV (Rotavirus)									
MMR (Measles Mumps, Rubella)									
Varicella (Chickenpox)									
Hep A (Hepatitis A)									

Other vaccinations

	Date	Date	Date	Date	Date	Date	Date	Date	Provider signature
Flu vaccine (one dose each fall or winter)									
Meningococcal vaccine									
Tetanus									
Human papillomavirus (HPV)									

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Patient home medicine list

We will ask to see your medicines or list.

Patient name: _____ **Date of birth:** ____/____/_____

It is important to know all of the home medicines your child takes.

- Bring all of your child's home medicines to the medical center.
- Make a list of everything that your child is taking.

Please include all:

1. Scheduled and "take as needed" prescription medicines.
2. Over-the-counter (OTC) medicines, vitamins, supplements, herbals and home remedies.
3. Inhalers, breathing treatments, eye drops, ear drops or medicated cream or lotions.

Our nurse or pharmacist will ask to see your medicines or list. This is an *example* of the information we need.

1. Medicine name	Tylenol® (or generic name acetaminophen)
2. Strength of medicine	325 mg
3. Dose you give and how	1 tablet by mouth
4. How often	Every 4 hours as needed
5. Reason you take medicine	As needed for pain
6. Time you gave the last dose	Monday at 8 a.m.

Tylenol tablets 325 mg.

Take 1 tablet by mouth

Every 4 hours as needed for pain

Medicine	Strength	Dose	How you take it	Time you take it	Reason for medicine	Last taken
Tylenol	325 mg tab	1 tab	By mouth	Every 4 hours as needed	Pain	1/1/15 8am

Helpful information:

1. Bring a current list of your child's medicines each time you go to the doctor, clinic, emergency room, etc.
2. Use your cell phone to keep track of medicines. Create a "medicine list" memo or take pictures of each medicine bottle. You can also try a smartphone app like *MyMedSchedule* or *MediSafe Meds & Pill Reminder* for managing medicines.
3. If your child uses a Cook Children's doctor, you can track medicines on the Cook Children's patient portal. mycookchildrens.org
4. If you fill prescriptions at a major pharmacy, you may be able to view medicine information through the pharmacy's website or mobile app.
5. Our **Cook Children's Retail Pharmacy** is located near the Emergency Department. If you would like to use this service, simply ask the doctor to send your child's prescriptions to the Cook Children's Retail Pharmacy.

These instructions are only general guidelines. Your doctors may give you special instructions. If you have any questions or concerns, please call your doctor.

My child's home medicine list

List all of your child's prescriptions and over-the-counter medicines, vitamins, herbs, food supplements and natural or home remedies. It is important to include all of this information in case of an emergency. Carry this list with you or on your cell phone. Show this list to all of your doctors, pharmacists or other caregivers.

Medicine	Strength	Dose	How you take it	Time you take it	Reason for medicine	Last taken

Name of pharmacy I use:	**Location:**
Pharmacy phone number:	

Notes:

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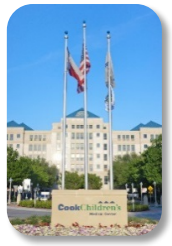
801 7th Ave.
Fort Worth, TX 76104
682-885-4000
cookchildrens.org



Helpful hint: Keep instruction manuals where you can find them!

Durable medical equipment (DME)/supplies

Name of equipment:_____

Ordered by (provider):_____

Phone: _____ Account or ID #: _____

Description (brand name, size, etc.):_____

_____

Serial #/model: _____Supplier: _____

Daytime phone:_____After hours phone:_____

Date ordered:_____Date received:_____

Name of equipment:_____

Ordered by (provider):_____

Phone: _____ Account or ID #: _____

Description (brand name, size, etc.):_____

_____

Serial #/model:_____ Supplier: _____

Daytime phone:_____After hours phone:_____

Date ordered:_____Date received:_____

Name of equipment:_____

Ordered by (provider):_____

Phone: _____ Account or ID #: _____

Description (brand name, size, etc.):_____

_____

Serial #/model: _____Supplier: _____

Daytime phone:_____After hours phone:_____

Date ordered:_____Date received:_____

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