Medical

Other Documents That I Could Add to This Section:

- ☐ Diagnostic Assessments
- ☐ Lab Results
- ☐ Written Instructions after Discharge from Hospital or ER
- ☐ Consent/Permission for Medical Treatment form
- ☐
- ☐

Medical Insurance & Managed Health Care

Place a copy of your card(s) in your binder OR fill out the information below.

State of Minnesota- Managed Health Care
Member Help Desk: 651-431-2670 or 800-657-3739

Case Worker and Contact Info _____

Program Name (Ex. MinnesotaCare, Medical Assistance/ MA) _____

Member # _____

Member Name _____

Birthdate _____

Rx BIN _____

SAMPLE CARD


Minnesota Health Care Programs
Present this card every time you go for medical care.
Member Number 1234567890
Member Name JANE A DOE
Birth Date 11/15/2005
Gender FEMALE
Rx BIN 610459
More information on back of card.

Name of Health Plan (Ex. Blue Plus, Health Partners, UCare) _____

Health Plan ID _____

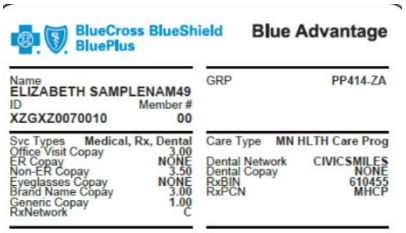
Member # _____

Group #_____

Dental Network _____

Customer Service Phone # _____

SAMPLE CARD


BlueCross BlueShield BluePlus
Blue Advantage
Name ELIZABETH SAMPLENAM49
ID XZGXZ0070010
Member # 00
GRP PP414-ZA
Svc Types Medical, Rx, Dental
Office Visit Copay 3.00
ER Copay NONE
Non-ER Copay 3.50
Eyeglasses Copay NONE
Brand Name Copay 3.00
Generic Copay 1.00
RxNetwork C
Care Type MN HLTH Care Prog
Dental Network CIVICSMILES
Dental Copay NONE
RxBIN 610455
RxPCN MHCP

Primary Medical Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Medical Insurance & Managed Health Care

Place a copy of your card(s) in your binder OR fill out the information below.

Secondary Medical Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Dental Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Vision Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Medical History- Tracking and Sharing

Here are a few ideas for tracking and sharing your child's medical history.

Your Care Binder

Fill out the medical charts in this section of your Care Binder. Then, share with anyone who needs medical information. Since these are paper forms, you will have to make sure they are up to date. And, of course… you have to remember to bring your Binder!

Emergency Information Form (EIF)

Ask your doctor/provider to fill out and sign the Emergency Information Form for Children with Special Health Care Needs. (We include the form in your Care Binder.)

- Share a copy with other members of your child's support team.
- During a crisis, give your completed form to Ambulance/EMS, Police, or Emergency Room
- Interactive and Printable Forms are available online here: https://www.acep.org/by-medical-focus/pediatrics/medical-forms/emergency-information-form-for-children-with-special-health-care-needs/#sm.00017q9m7o176eezu3m1v8zguubnh

  "The American College of Emergency Physicians and the American Academy of Pediatrics are pleased to present the Emergency Information Form (EIF). This important document will assure prompt and appropriate care for Children with Special Health Care Needs (CSHCN). Now, when these patients present to emergency departments or health care professionals with an acute illness or injury, physicians, parents, EMS professionals, and nurses will be able to use the EIF as a tool to transfer critical information. The EIF will ensure that a child's complicated medical history is concisely summarized and available when it is needed most - when the child presents with an acute health problem at a time when neither parent nor pediatrician is immediately available. AAP and ACEP believe the EIF is an important tool that will help facilitate the transfer of relevant information for Children with Special Health Care Needs."

Minnesota Standard Consent Form to Release Health Information (ROI)

If you want doctors or service providers to be able to share information with each other, you need to fill out a Release of Information(ROI) form. Doctors, hospitals, therapists, and schools etc. will all have similar forms that you can use. Unfortunately, they do not always accept each other's ROI forms. This standard form was developed by the Minnesota Department of Health. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act.

- Psychotherapy Notes that are kept by your child's psychiatrist, psychologist or other mental health professional are kept in a separate filing system in their office and not with your other health information. So, if you are requesting the release of psychotherapy notes, you have to use a new blank form and only check that category. You must also

name the professional who will release the psychotherapy notes. (We included 2 Forms in your Care Binder.)

Ask your providers to give you copies of the ROI forms that you have already signed. Hole punch them and keep them in this section of your Binder so you can monitor who has what information about your child(ren). This can also help you determine who else needs a release so they can collaborate on your child's care.

Paper Forms--- Stored Online

If you are worried that you might forget to bring your Care Binder, you could fill out and then save the pages from this binder to a secure cloud-based storage or an e-health tool. Some people also choose to take photos of important pages and stored them on their phone.

Online Parent Portals

Some medical systems have an online Parent Portal. These are helpful because the information is up-to-date and can be viewed by the doctor and the parent. Unfortunately, when your child is seen by several providers and systems, you may end up with several online Parent Portals. And, different providers/ medical systems are not always able to share information between portals.

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name: **Birth date:** **Nickname:**

Home Address: **Home/Work Phone:**

Parent/Guardian: **Emergency Contact Names & Relationship:**

Signature/Consent*:

Primary Language: **Phone Number(s):**

Physicians:

Primary care physician: **Emergency Phone:**

Fax:

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Anticipated Primary ED: **Pharmacy:**

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations (mm/yy)

Dates						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information.

This helps prevent others from changing your form.

EXAMPLE: jh All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

THE GREAT SEAL OF THE STATE OF MINNESOTA L'ETOILE DU NORD 1858

AUGUST2015

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ (MM / DD / YYYY) Previous name(s) _____

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (MM / DD / YYYY) (optional)

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

Diagnoses

My Child's Name _____

Diagnosis	Abbrev.	Doctor(s) who diagnosed	Doctors' Specialty	Date of diagnosis	Notes
Acute Stress Disorder	*ASD*	*Dr. Moana*	*Psychiatrist*	*1/6/2015*	*Need to watch to see if this turns into PTSD*

Medications

My Child's Name _____

Medication	Dosage	Time of day	Start Date and Reason	End Date and Reason	Ordered by	Notes (Improvements and side effects)
Lexapro	*20 mg*	*Bedtime*	*11/1/2016 Depression*	*12/15/2018 Slowed growth rate*	*Dr. Maui*	*Less suicidal thinking*

Medications

My Child's Name _____

Medication	Dosage	Time of day	Start Date and Reason	End Date and Reason	Ordered by	Notes (Improvements and side effects)
Lexapro	*20 mg*	*Bedtime*	*11/1/2016 Depression*	*12/15/2018 Slowed growth rate*	*Dr. Maui*	*Less suicidal thinking*

Hospital/ Facility Stays

My Child's Name _____

Reason for Admission	Admission Date	Discharge Date	Hospital/Agency, Doctor	Telephone	Notes
Appendix removed	*5/5/2014*	*5/7/2014*	*Tefiti Regional, Dr. HeiHei*	*555-444-3333*	*Surgery successful*

Treatment History

My Child's Name _____

Treatment	Start Date	End Date	Provider	Notes (What worked? What didn't?)
TF-CBT	*6/1/15*	*Current*	*Dr. Tamatoa*	*Had less nightmares and tantrums after this! We felt closer after she shared her story in therapy*

FAMILY Medical History

My Child's Name _____

Has anyone in your child's family experienced these physical health disorders:

X	Condition	Family Member	Notes
☐	Genetic Conditions		
☐	Heart Problems		
☐	Developmental disability		
☐	Seizure disorder		
☐	Diabetes		
☐	Blood disorder		
☐	Cancer		
☐	Vision or hearing impairment		
☐	Metabolic or nutritional disorder		
☐			
☐			

Has anyone in your child's family experienced these mental health disorders:

X	Condition	Family Member	Notes
☐	Depression		
☐	Anxiety		
☐	Bi-Polar Disorder		
☐	Post-Traumatic Stress Disorder		
☐	Drug or Alcohol Addiction		
☐	Schizophrenia		
☐			
☐			

CHILD Medical History My Child's Name _____

X	Condition	Notes
☐	Asthma	
☐	Blood disorder	
☐	Bone/Joint problems	
☐	Bowel control problems	
☐	Cancer	
☐	Chickenpox	
☐	Developmental disability	
☐	Diabetes	
☐	Ear infection	
☐	Eczema	
☐	Excessive vomiting	
☐	Genetic Conditions	
☐	German Measles (Rubella)	
☐	Heart Problems	
☐	Infectious Mononucleosis	
☐	Measles (Rubeola)	
☐	Meningitis	
☐	Metabolic/nutritional disorder	
☐	Mumps	
☐	Pertussis (Whopping Cough)	
☐	Respiratory Infections	
☐	Rheumatic Fever	
☐	Roseola	
☐	Scarlet Fever	
☐	Seizure disorder	
☐	Strep Throat	
☐	Vision or hearing impairment	
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Allergies

My Child's Name _____

Allergy	Type of Reaction

Past Stressful Experiences or Trauma

My Child's Name _____

Has your child experienced any of the following?

X	Condition	Notes
☐	Bullying	
☐	Death of a loved one	
☐	Domestic violence	
☐	Emotional abuse	
☐	Gun violence	
☐	Homelessness	
☐	Loss of a pet	
☐	Not enough food	
☐	Parent in Jail	
☐	Physical abuse	
☐	Separation from parents	
☐	Severe Illness or surgery	
☐	Sexual abuse	
☐	War or refugee experience	

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.