Transition Program

Children's Mercy KANSAS CITY

_____ Health Passport

Date: _____

(Enter Specialty Diagnosis)

Name: _____ **DOB:** _____

Phone: _____ *Email:* _____

Insurance: _____

_____ **Office Phone:** _____

(Enter Specialty)

PCP: _____ **Office Phone:** _____

Pharmacy: _____ **Office Phone:** _____

Emergency Contact: _____ **Contact Phone:** _____

Guardian: _____ **Contact Phone:** _____

Photo/Image of dx. example	**Most prevalent test results related to dx.**

_____ (dx specific test results)

_____ (dx specific test results)

_____ (dx specific test results)

Allergies: _____

Medications: _____

Medical Devices: _____

Company: _____

DME Equipment: _____

Company: _____

Diagnosis-related Labs: _____

Oxygen: Yes ☐ No ☐ **Baseline O2:** _____

Activity Restrictions: _____

Pregnancy Considerations: Yes ☐ No ☐ **Contraception:** _____

Previous Tests/Procedures: _____

Follow-up Appointment Info:

**Disclaimer: This document is up to date as of . Information is subject to change.