Dover Pediatrics
PEDIATRIC & ADOLESCENT MEDICINE

Family Questionnaire for Patient Care Plan Preferences

Today's Date: _____ ***Completed by:*** □ **Parent** □ **Guardian** □ **Patient**

Child's Name: _____ **DOB:**_____/_____/_____

Your Name: _____ **Phone: (_____)**_____

- ***Are there any special circumstances you would like us to know:***_____

_____

_____

- ***Do you believe the current Care Plan incorporates patient preferences and functional/lifestyle goal(s)?*** □***Yes*** □***No***

_____

- ***Does the patient/parent/guardian have any new treatment goals?***_____

_____

- ***What do you see as potential barriers to meeting the goals outlined above?***_____

_____

_____ _____

Parent/Guardian Signature **Date**

_____

Primary Care Provider Signature **Print Name** **Contact Info** **Date**

_____

Care Coordinator Signature **Print Name** **Contact Info** **Date**

To be completed by Care Coordinator:

- ***Copy of this Care Plan has been provided to the family/guardian?*** □ *Yes - Date:* _____ □ *No*
- ***Copy of this Care Plan forwarded to:*** □ WDH ED □ Other Providers- please list: _____
- ***Have instructions and/or resources been provided to the patient and/or family?*** □ *Yes* □ *No*

  Please describe:_____