THE UNIVERSITY OF CHICAGO MEDICINE

Med-Peds PATHways

Program for Adolescent and Adult Transition to Health

Date of referral: _____

Patient Name: _____ Patient DOB: _____MRN_____

Parent/Guardian:_____ Phone: _____

Referring Physician: _____

Phone:_____ Fax:_____ Email:_____

Please indicate follow up contact preference:

◯ phone ◯fax ◯email ◯EPIC ◯preferred other contact _____

MP PATHways provides transition support with portable medical summary, youth-centered transition plan, and information about community resources and services.

Reason for referral:

_____

Please indicate specific youth and family interests or needs: We plan to focus on **top three** at the first visit, helping the youth and family with other topics at subsequent visits.

_____ Preparation for transfer to an adult provider (Specialty type _____ if applicable)
(Age at which you plan to transfer youth from your practice_____)

_____ Future health care financing issues

_____ Decision-making development and legal support recommendations

_____Develop youth's health self-management skills

_____ Develop youth's activities of daily living skills

_____ Assist with parenting approach through transition process

_____ Recommendations for secondary school transition plan/IEP

_____ Post-secondary education/employment recommendations

_____Clinical accommodations due to disability, i.e. hi-lo table, visual cuing, facilitated exams

_____Assess and refer behavioral concerns to appropriate services

_____ Referral to community resources for adaptive services/supports

_____ Other : _____

(Please attach last office note, relevant past history, immunizations, etc. as available)

Please fax this form to 773-834-3950

Page for inpatient or outpatient consults X6788 (MPTT: Med-Peds Transition Team) or if you have a question regarding the PATHways clinic.

Modified with permission form CYACC, Indiana University