

**PEOPLES COMMUNITY HEALTH CLINIC—PEDIATRICS
 MEDICAL HOME INITIATIVE ADD/ADHD
 Self-Management Goals for Parents/Caregivers**

Name: _____ Date: _____

Key Parent/Caregiver Goals	Circle your level of confidence in completing each goal:
1. Learn more about ADD/ADHD and how it affects my child.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
2. Make follow up appointment for next office visit before leaving clinic today.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
3. Call for refill of medication 2 days before out of medication.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
4. Get medicine refilled before child is out of medication.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
5. Give medicine as ordered by your doctor.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
6. Come with your child to all follow up appointments.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
7. Talk with your child's teacher's regularly or often about your child's progress.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
8. Attend all school conferences.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
9. Call the clinic if you have any concerns between appointments.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident
10. Keep your child's next scheduled appointment.	Cannot Meet Goal 0 1 2 3 4 5 Completely Confident

I would like help with the following:	Yes	No
Developing a strong relationship with my child		
Help with affording medications		
Family support group information		
Positive Discipline Techniques		

Other comments or concerns I have are:

Between today and our next visit, one goal I would like to work on is:

Progress on Goals Notes:
Date: _____ 1. _____
Date: _____ 2. _____
Date: _____ 3. _____
Date: _____ 4. _____
Date: _____ 5. _____

PEOPLES COMMUNITY HEALTH CLINIC, INC.

ADHD CARE PLAN

Date: _____

To the family of _____, please refer to this plan between visits if you have questions about care.
If you are still unsure, call us at _____ for assistance.

Goals what improvements would you most like to see? Specific behavior you would like to see improve:

At Home: _____

At School: _____

Plans to reach these goals:

1. _____
2. _____
3. _____

Medication

Dosage

Time

1. _____
2. _____

- Medication to be given on nonschool days Medication given for _____ number of days
 School authorization signed by parent Side effects explained/information provided

Common Side Effects: decreased appetite, sleep problems, transient stomachache, transient headache, behavioral rebound

Call your doctor immediately if any infrequent side effects occur: weight loss, increased heart rate and/or blood pressure, dizziness, growth suppression, hallucinations/mania, exacerbation of tics and Tourette syndrome (rare)

Follow Up Plan

- School testing schedule Date: _____
 Parent and Teacher Vanderbilts Completed: _____
 Other Professional _____

Additional Resources and Treatment Strategies

- F/U Parent Vanderbilt requested via: mail/email Completed: _____

The following Parenting Education Sheet provided:

- Attention Deficit Disorder (ADD), Attention Deficit Hyperactive
 - ADHD What Parents Should Know
 - The Disorder Named AD/HD—CHADD
 - Parenting a Child with AD/HD—CHADD
 - Attention Deficit Hyperactivity Disorder: Resource List
 - Attention-Deficit/Hyperactivity Disorder (ADHD) Overview
- Parent and Teacher contacted for Med Tracking
 Counseling Referral to: _____

Next Follow-up Visit: _____