STUDENT TRANSFER SUMMARY CHECKLIST

Complete summary and forward to the receiving center at least 2 weeks prior to student arrival (refer to PRH-6: 6.4, R2(c)). Each summary section must be completed.

GENERAL INFORMATION

Student Name: _____ DOB: _____ ID#: _____

Date of Entry: _____ Transferring Center: _____

Date of Transfer: _____ Receiving Center: _____

Insurance (check all that apply):

Private insurance: ☐ Yes ☐ No If yes, enter insurer: _____

Medicaid: ☐ Yes ☐ No If yes, enter state: _____

Other (specify): _____

Allergies: _____

Current medication(s) and dosage(s): _____

_____

Upcoming appointments (e.g., orthodontic, off-center healthcare provider): _____

_____

ACCOMMODATIONS

Check one:

☐ Accommodation plan is attached ☐ Student does not have an accommodation plan

Comments (include any specific additional information that needs to be known in relation to the student's accommodation plan such as the use of specific technologies or other information that was helpful in implementing the plan): _____

_____

_____

_____

_____

Disability Coordinator Signature: _____ *Date:* _____

Disability Co-Coordinator Signature: _____ *Date:* _____

HWM Signature: _____ *Date:* _____

MEDICAL

Date of last medical assessment: _____

Medical summary (include diagnoses, chronic/acute conditions, and treatments): _____

_____

_____

_____

_____

Activity/Diet/Vocational Restrictions: _____

Provider Signature: _____ *Date:* _____

ORAL HEALTH

Check all that apply:

- ☐ Refused elective oral examination
- ☐ Received elective oral examination
- ☐ Received oral health treatment
- ☐ Refused oral health treatment

If student received priority classification, current priority classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Does the student have orthodontics? ☐ Yes ☐ No

If yes, is an updated orthodontic treatment plan in place? ☐ Yes ☐ No ☐ N/A

Oral health summary (include diagnoses, chronic/acute conditions, and treatment): _____

_____

_____

_____

_____

_____

Center Dentist Signature: _____ *Date:* _____

TEAP

Entry Toxicology: ☐ Negative ☐ Positive If positive, list drug(s): _____

Suspicion testing dates/results (if applicable): _____

TEAP summary (include results of initial assessment, interventions, and dates of all contacts with TEAP Specialist): _____

_____

_____

_____

_____

_____

TEAP Specialist Signature: _____ *Date:* _____

MENTAL HEALTH

Check one:

- ☐ Student received mental health services
- ☐ Student did not receive mental health services

Mental health summary (include clinical impressions from initial intake assessment, interventions [on and/or off center], medications, and any other relevant care management contacts with the CMHC): _____

_____

_____

_____

_____

_____

CMHC Signature: _____ *Date:* _____