MEDICAL SUMMARY

FOR TRANSITIONING HYDROCEPHALUS PATIENT

INSTRUCTIONS

This document should be completed by medical providers, in collaboration with youth and their caregivers.

INTENT

This document should be shared with the transitioning patient's new medical providers, as well as the patient themselves and their caregivers, as appropriate. It is helpful if relevant legal documents are attached (e.g. Health Care Power of Attorney / Designation of Health Care Surrogate, etc.)

PATIENT INFORMATION

Patient Name: Date of Birth:

Email:

Parent or Caregiver Name: Relationship:

Email:

☐ This patient has a formal legal guardian appointed to make decisions for them as an adult. (Please attach legal documentation.)

PRIMARY PEDIATRIC HYDROCEPHALUS PROVIDER OR GROUP

Name:

Specialty:

City, State:

Work Number: Best Time to Reach:

Email: Best Way to Reach: ☐ Phone ☐ Email

Hydrocephalus Association

The American Society of Pediatric Neurosurgeons

HEALTH CARE PROVIDERS

Below list all health care providers with whom you receive care. This includes your primary care physician/pediatrician, specialty physicians such as neurosurgery, neurology, endocrinology, ophthalmology, neuropsychology, etc., rehabilitation specialists and occupational, physical, and speech therapists, and behavioral and mental health professionals. Use an additional sheet, if necessary.

NAME	SPECIALTY	PHONE/FAX	EMAIL

EMERGENCY CONTACT INFORMATION

Name: Relationship to Patient:

Cell: Phone (Other): Email:

Preferred Emergency Care Location:

PRIMARY CAUSE OF HYDROCEPHALUS

- ☐ Intraventricular Hemorrhage (IVH) related to Prematurity
- ☐ Other Hemorrhage (e.g. cerebellar, subarachnoid)
- ☐ Spina bifida/Myelomeningocele
- ☐ Aqueductal Stenosis
- ☐ Brain Tumor
- ☐ Dandy Walker Malformation
- ☐ Chiari I Malformation
- ☐ Cyst
- ☐ Head Injury
- ☐ Infection (e.g. meningitis, ventriculitis, encephalitis)
- ☐ X-Linked Hydrocephalus
- ☐ Other
- ☐ Unknown/Unsure

Additional Information:

AGE FIRST TREATED FOR HYDROCEPHALUS

- [ ] Infant (birth to 1 year old)
- [ ] Child (1 – 10 yrs old)
- [ ] Pre-teen/Teen (11 – 18 yrs old)

CURRENT PRIMARY TREATMENT (check all that are currently active)

- [ ] Shunt
- [ ] ETV
- [ ] ETV/CPC
- [ ] No Treatment

Is your shunt currently working to treat your hydrocephalus? [ ] Yes [ ] No

Have you ever had an ETV or ETV/CPC? [ ] Yes [ ] No

Is your ETV currently working to treat your hydrocephalus? [ ] Yes [ ] No

- [ ] Check here if the surgeon who performed the last hydrocephalus surgery is the same as the pediatric neurosurgeon listed above.

If not, name and location of surgeon who performed the last hydrocephalus surgery:

PRIMARY SHUNT TYPE

- [ ] VP (Abdomen)
- [ ] VA (Heart)
- [ ] LP (Spine)
- [ ] VPL (Lung)

SHUNT CONFIGURATION

What type of shunt valve do you have?

Shunt manufacturer and model:

Setting, if programmable:

Other devices used with your shunt (e.g. Antisiphon Device (ASD) and setting, ReFlow, etc.):

If you have more than one valve and one proximal catheter, please describe your configuration here:

Is your treatment information stored in the HydroAssist mobile app? [ ] Yes [ ] No

(Download HydroAssist for free from the Apple App Store or Google Play, or scan the QR code below.)

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HYDROCEPHALUS TREATMENT HISTORY

of hydrocephalus-related surgeries (estimate, if necessary)

Date of most recent hydrocephalus surgery:

Date of imaging showing typical failure:

Date of imaging showing baseline ventricles:

Typical signs and symptoms of failure:

Other major medical conditions (that you see a doctor for regularly):

Additional notes or information not covered above:

(This should include chronic symptoms you experience outside of shunt failure (e.g. headaches, extremity weakness, etc.) and if there is a pattern in the day/week/month these typically are worse.

FOR PHYSICIANS ONLY – PHYSICIAN TO PHYSICIAN COMMUNICATION

For treating physicians, please share information not captured in this form that is important for the receiving physician to know when treating this patient. Examples of the types of information to share here include:

◊ Considerations for shunt failure with this patient. (e.g. This patient has non-compliant ventricles...)

◊ Treatment interventions to avoid based on lessons learned. (e.g. This patient's shunt setting should never go above X ...)

◊ Previous shunt manipulations attempted to address chronic symptoms.

◊ Surgical complications of which the new treating physician should be aware. (e.g. This patient has difficult abdominal access; involve general surgery.)

SIGNATURES

Patient Name (Printed) ____________________ Phone Number ____________

Patient Signature ____________________ Date ____________

Parent/Guardian Name (Printed) ____________________ Phone Number ____________

Parent/Guardian Signature ____________________ Date ____________

Primary Pediatric Hydrocephalus Provider Name (Printed) ____________________

Primary Pediatric Hydrocephalus Provider Signature ____________________

Phone Number ____________ Date ____________

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For comments or feedback on this form, please email info@hydroassoc.org.