**STUDENT TRANSFER SUMMARY FORM**

Complete summary and forward to the receiving center at least 2 weeks prior to student arrival (refer to PRH-6: 6.2, 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 [ ]  Refused oral health treatment

[ ]  Received elective oral examination [ ]  Received 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**

Check one: [ ]  Student received TEAP services [ ]  Student did not receive TEAP services

TEAP summary (include results of initial assessment, interventions services and clinical recommendations as well as any other relevant information):

*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:*

**If you have any questions, please contact:**

**HWM Printed Name Phone Number**

**HWM Signature Date**