**Appendix**

**1. Patient Data**

*Card to Carry*

|  |  |
| --- | --- |
| Patient Name | Identifying information (date of birth, MRN)Emergency Contact  |
| Operation | Name of / type of operationOperative diagramDate of operationSurgeon who performed operationHospital where operation occurred Brief summary of key technical points specific to patientShort or long segmentSummary of pathology  |
| PMH/PSH | All relevant medical and surgical history  |
| Medications | Daily medications  |
| Bowel Regimen | Daily and / or PRN medications for constipation or diarrhea |
| Allergies | Drug allergies |

*Patient / family should keep at home:*

* Operative Report(s)
* Pathology report(s)
* Relevant discharge summaries

**2***.* **Hirschsprung Transitional Care Medical Summary and Emergency Care Plan**

Date Completed:

Date Received:

Form Completed By:

**Contact Information**:

Name:

(Include Maiden Name if applicable)

Nickname:

DOB:

Native language:

Parent (Caregiver):

Relationship:

Primary Address:

Cell phone:

Home phone:

Email:

Preferred form of contact: Text / Phone (cell or home) / Email

Health insurance plan:

Group and ID#:

**Emergency Care Plan:**

Emergency Contact:

Relationship:

Phone:

**Allergies:**

List allergens and associated reactions:

**History of Diagnosis and Surgery:**

|  |  |  |
| --- | --- | --- |
|  | Date | Surgeon/Hospital performed  |
| Rectal biopsy  |  |  |
| Original surgery |  |  |
| Original transition zone(Anatomic segment above dentate line)  |  |  |
| Previous surgical complications |  |  |
| Last exam under anesthesia |  |  |
| Last hospitalization |  |  |

**Review of Surgical Repair:**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Dentate line intact |  |  |
| Sphincters intact  |  |  |
| Transition zone pull-thorough |  |  |
| Retained obstructive Soave cuff  |  |  |
| Obstructing Duhamel pouch |  |  |
| Duhamel spur |  |  |
| Twisted pull-through |  |  |
| Anastomotic stricture |  |  |
| Wound dehiscence within first 7 days post-op  |  |  |
| Continent for stool  |  |  |

**Stooling Habits**:

(medications used, enema regimen)

**History of Enterocolitis**:

(please distinguish between pre and post surgery)

**Additional Past Medical History:**

**Additional Past Surgical History**:

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Procedure | Surgeon | Hospital |
|  |  |  |  |
|  |  |  |  |

**Medications:**

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
| 1. |  |  |
| 2. |  |  |

**Pertinent Radiology/Testing:**

|  |  |  |
| --- | --- | --- |
| Test | Date | Results |
| Abdominal x-ray |  |  |
| Contrast enema |  |  |
| Anorectal manometry  |  |  |