Hôpitaux Shriners pour enfants®
Shriners Hospitals for Children®
Canada

OI* Transfer Summary

to facilitate the transition between pediatric and adult care

Contact Information

Full Name		Preferred Name
Home Address		E-mail Address
Home Phone Number		Cell Phone Number
Emergency Contact 1	Relationship	Phone
Emergency Contact 2	Relationship	Phone

General Information

Date of Birth			
Spoken Languages	English ☐	French ☐	Other ☐
Preferred language of communication	English ☐	French ☐	Other ☐
Cultural and Religious Considerations			
Financial Assistance / Private Insurance / Other			
Applications to Welfare / Disability			
Methods of Transportation			
Service Animals			
I would like ☐Mother ☐Father ☐Significant other ☐Other _____ to be involved with my care.			
Signed Release of Information Form from Treating Center ☐Yes ☐No			
General Concerns			

OI* = Osteogenesis Imperfecta

Psychosocial

Learning needs and accommodations for school, work and / or leisure	
Current Living Arrangement	Future Living Arrangement
Volunteer Experience	
Post-Secondary Education / Employment	
Post-Secondary Education Concerns (eg.: adapted campus/residence, funding, resources)	
Sources of Social Support (eg.: peers, family, friends, partners, etc.)	
Previous or current history of distress / anxiety / depression / other mental health concerns	
Best person / people to talk to when feeling distressed / anxious / depressed	
Sexual & Reproductive Health Concerns	
Pets	
Hobbies	
Other Psychosocial Concerns	

General Medical Information

Allergies	Height	Weight Date of Last Weight
Immunizations and flu vaccines		
Dietary Needs		
Lifestyle Habits (eg.: diet, alcohol, drugs, exercise, etc.)		
Participation in Clinical Research		

Family History

Family History of OI
Other Medical Family History (eg.: diabetes, heart disease, cancer, etc.)

Medical Diagnoses & History

Medical Diagnoses		
Presence of Dentinogenesis Imperfecta: ☐Yes ☐No		
Type of OI	Date of Last Fracture	Total number of fractures
Major Surgeries		
Major Hospitalizations		
Treatments		
Pain & Pain Management	Acute (location, strategies, resources)	
	Chronic (location, strategies, resources)	
Other or Ongoing Medical Concerns		

Current Prescribed Medication(s)

Medication name	Dose	Frequency	Start date / How long have you been taking it?	Reason for taking this medication?

Recent Lab Results, X-Rays, Etc.

Test & Date of last test	Results Summary	
Bone Mineral Density		Z-score BMD
Pulminary Function test		
Other (specify)		
Other (specify)		
X-Rays for fractures done at which institutions?		
Abnormal test results Date	Action taken	Outcome

Medical Equipment, Orthotics, Assistive Devices

Equipment	Provider	Provider Contact

Functional Capabilities & Independence Level

Mobility & Transfers
Activities of Daily Living (eg.: eating, bathing, dressing, toileting, transferring, continence)
Instrumental Activities of Daily Living (eg.: housework, groceries, management of money / medications, etc.)

Follow-up Requirements / Other Professionals & Community Services

Healthcare Professional / Organisation	Medical test / Procedure / Service	Frequency	Contact information / Department
Patient seen by rehabilitation services? ☐Yes ☐No			
Patient seen by Community Health Centre or other hospitals? ☐Yes ☐No			
Patient seen by dentist? ☐Yes ☐No			

General Concerns

For information for parents, youths, adults and health care professionals, please visit:

- OI Foundation (www.oif.org)
- Brittle Bone Society (www.brittlebone.org)
- OI Australia (www.oiaustralia.org.au)
- OI Federation of Europe (www.oife.org)
- Care 4 Brittle Bones Foundation (www.care4brittlebones.org)

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