Patient Pathways
INDEPENDENT HEALTHCARE NAVIGATORS & ADVOCATES

IN CASE OF MEDICAL EMERGENCY CALL 911

PARAMEDICS & FIRST RESPONDERS | PLEASE READ & TAKE TO HOSPITAL

COVER PAGE – INCLUDED IN THIS PACKET ARE FORMS FOR:

Name: _____ Completed date *[yyyy-mm-dd]*: _____

Date reviewed: _____

Date reviewed: _____

Name: _____ Completed date *[yyyy-mm-dd]*: _____

Date reviewed: _____

Date reviewed: _____

Name: _____ Completed date *[yyyy-mm-dd]*: _____

Date reviewed: _____

Date reviewed: _____

Name: _____ Completed date *[yyyy-mm-dd]*: _____

Date reviewed: _____

Date reviewed: _____

Review your documents <u>every year</u> OR when any of the following occur:

- any medication changes (dosage, new or discontinued medication)
- a change in *any* diagnosis or health status
- any hospitalization
- a change in your Representative(s) or Substitute Decision Maker(s)
- a serious diagnosis or death of a loved one

Patient Pathways

INDEPENDENT HEALTHCARE NAVIGATORS & ADVOCATES

MEDICAL INFORMATION | IN CASE OF AN EMERGENCY CALL 911

Full name *[Last name, Given names]*: _____

Personal health number: ☐☐☐☐☐☐☐☐☐☐

Address: _____

Main phone: _____ Alternate phone: _____

Birth date *[yyyy-mm-dd]*: _____

Languages Spoken: _____

Date completed *[yyyy-mm-dd]*: _____

DOCUMENTS INCLUDED WITH THIS ICE FORM:

- ☐ Legal form naming Substitute Decision Makers *[see instructions]*
- ☐ No CPR or Do Not Resuscitate signed medical order or request on Directive *[some provinces require signed medical order]*
- ☐ Advance/Health Care/Personal **Directive** or Personal POA *[depending on province]*
- ☐ Expected Death Form for those nearing end of life, signed by practitioner
- ☐ Registered Organ Donor **OR** Opted-out of Organ Donation *[for applicable provinces]*
- ☐ Funeral arrangements and after-death care of body instructions
- ☐ Enduring Power of Attorney

Other important details can be found:

IMPORTANT CIRCUMSTANCES:

Examples: "I care for my husband Jack. He has dementia and can't be left alone; call his brother Fred," or "Sally has autism and is nonverbal," or "I am deaf without my hearing aids."

Name: _____ PHN: _____

LIFE THREATENING ALLERGIES:

[Most important and recent at top. Example for "What to do: Benadryl or Epi Pen".]

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

Allergen: _____
Reaction: _____ What to do: _____

MOBILITY AND SENSORY ISSUES:

- ☐ Paralysis
- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Scooter
- ☐ Prosthetic limb
- ☐ Dentures
- ☐ Swallowing
- ☐ Autism spectrum
- ☐ Nonverbal
- ☐ Low/No hearing
- ☐ Hearing aid
- ☐ Low/No vision
- ☐ Eyeglasses
- ☐ Contact lenses
- ☐ Other: _____

Name: _____ PHN: _____

MEDICAL CONDITIONS & RECENT SURGERIES: *[Most important and recent at top]*

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Conditions: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Name: _____ PHN: _____

MEDICAL CONDITIONS & RECENT SURGERIES – CONTINUED:

[Most important and recent at top]

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Conditions: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Condition: _____
Year diagnosed/treated: _____ Notes: _____

Name: ______________________ PHN: ☐ ☐ ☐

PRESCRIPTION MEDICATION RECORD:

Where these prescribed medications are kept:

☐ Kitchen/Fridge
☐ Bathroom
☐ Bedroom
☐ Purse/bag
Other: ______________________

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________
○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**
Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Name: ______________________

PHN: [ ] [ ] [ ]

PRESCRIPTION MEDICATION RECORD – CONTINUED:

Where these prescribed medications are kept:

- ☐ Kitchen/Fridge
- ☐ Bathroom
- ☐ Bedroom
- ☐ Purse/bag
- Other: ______________________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Prescribed By: ○ **GP** ○ **Specialist**

Name: ______________________ PHN: [ ] [ ] [ ]

NON-PRESCRIPTION MEDICATIONS, OINTMENTS & SUPPLEMENTS:

Where these non-perscribed medications are kept:

- ☐ Kitchen/Fridge
- ☐ Bathroom
- ☐ Bedroom
- ☐ Purse/bag
- Other: ______________________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Drug: ______________________ Dosage: __________

○ **Oral** ○ **Inhaler** ○ **Patch** ○ **Ointment** ○ **Injection** When: ☐ **Morning** ☐ **Lunch** ☐ **Supper** ☐ **Bedtime**

Taken for: ______________________ Recommended by: __________

Name: _____ PHN: _____

SUBSTITUTE DECISION MAKERS: *[this can be an informal list but strongly consider naming your SDMs in a legal document – see instructions]*

Name: _____ Relationship: _____
Primary phone: _____ Secondary phone: _____

Name: _____ Relationship: _____
Primary phone: _____ Secondary phone: _____

CURRENT PHYSICIANS:

Family physician: _____ Phone: _____
Address: _____ Last seen [yyyy-mm]: _____
Notes: _____

Specialist physician: _____ Specialty: _____
Phone: _____ Last seen [yyyy-mm]: _____
Notes: _____

Specialist physician: _____ Specialty: _____
Phone: _____ Last seen [yyyy-mm]: _____
Notes: _____

Specialist physician: _____ Specialty: _____
Phone: _____ Last seen [yyyy-mm]: _____
Notes: _____

Specialist physician: _____ Specialty: _____
Phone: _____ Last seen [yyyy-mm]: _____
Notes: _____

Name: _____ PHN: _____

PERSONAL AND HOUSEHOLD CONTACTS: *[Examples: "Building manager, friend with key"]*

Name: _____ Phone: _____
Role: _____
Notes: _____

Name: _____ Phone: _____
Role: _____
Notes: _____

Name: _____ Phone: _____
Role: _____
Notes: _____

Name: _____ Phone: _____
Role: _____
Notes: _____

Name: _____ Phone: _____
Role: _____
Notes: _____

NOTES: