

Your Smooth Transition Coach is:

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_



## Personal HEALTH RECORD

*Better Communication for Better Care*



General comments in this publication are based on research and the experience of those involved in the composition and editing of the individual piece, and should not be taken as a formal consultation or recommendation for a patient, disease state, or treatment approach.

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## Section 1 : General Information

### IDENTIFICATION

Last Name

First Name

Middle Initial

Address

City

State

Zip Code

Home Phone

Work Phone

Mobile Phone

Date of Birth (MM/DD/YYYY)

Sex:  Male  Female

### EMERGENCY CONTACTS

In Case of Emergency, Notify (Primary Contact)

Relationship

Address

City

State

Zip Code

Home Phone

Work Phone

Mobile Phone

### HEALTH INSURANCE INFORMATION

Primary Health-Insurance Provider Type:  Private  Medicare  Medicaid  Other

Company Name (If Private)

Member (ID) Name

Group Plan Number

Phone Number

Primary Insured (Name, If Different From Listed Above)

Secondary Health-Insurance Provider Type:  Private  Medicare  Medicaid  Other

Company Name (If Private)

Member (ID) Name

Group Plan Number

Phone Number

Primary Insured (Name, If Different From Listed Above)



**Section 1 :**  
**General Information** *(continued)*

**HEALTH HISTORY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alzheimers<br>_____ | <input type="checkbox"/> Heart Condition<br>_____  | <input type="checkbox"/> Seizures<br>_____                              |
| <input type="checkbox"/> Arthritis<br>_____  | <input type="checkbox"/> Hepatitis<br>_____        | <input type="checkbox"/> Stomach, Liver or Intestinal Problems<br>_____ |
| <input type="checkbox"/> Asthma<br>_____     | <input type="checkbox"/> High Cholesterol<br>_____ | <input type="checkbox"/> Stroke<br>_____                                |
| <input type="checkbox"/> Cancer<br>_____     | <input type="checkbox"/> High B/P<br>_____         | <input type="checkbox"/> Thyroid Disorders<br>_____                     |
| <input type="checkbox"/> Diabetes<br>_____   | <input type="checkbox"/> Kidney Disease<br>_____   | <input type="checkbox"/> Tuberculosis<br>_____                          |
| <input type="checkbox"/> Emphysema<br>_____  | <input type="checkbox"/> Mental Illness<br>_____   | <input type="checkbox"/> Tumor<br>_____                                 |
| <input type="checkbox"/> Glaucoma<br>_____   | <input type="checkbox"/> Rheumatic Fever<br>_____  | <input type="checkbox"/> Other<br>_____                                 |

**LIFESTYLE**

Do you drink alcohol?  Yes  No If yes, how many times per week? \_\_\_\_\_

\_\_\_\_\_

Do you smoke cigarettes?  Yes  No If yes, how many times per week? \_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, what type of exercise, how many times per week and for how long? \_\_\_\_\_

\_\_\_\_\_



## Section 2 : Advance Directives

### ADVANCE DIRECTIVES

**1. The Living Will**

Any adult person may, at any time, make a written declaration directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal and irreversible condition or is in a continual, profound comatose state with no reasonable chance of recovery.

**2. Durable Power of Attorney**

Any adult person may, at any time, through execution of a Durable Power of Attorney, designate another person to make treatment decisions for him/her in the event such person should be diagnosed as having a terminal or irreversible condition or in a continual, profound comatose state with no reasonable change of recover, and is unable to participate actively on his/her own behalf.

**3. Do Not Resuscitate (D.N.R.)**

It instructs medical personnel not to perform life-saving **cardiopulmonary resuscitation** (CPR) or other procedures to restart the heart or breathing once they have ceased. Once signed, the DNR directive must be placed in the patient's chart.

**Please read the following four statements:**

1. I have been given written materials about my right to accept or refuse services.
2. I have been informed of my rights to formulate Advance Directives.
3. I understand that I am not required to have an Advance Directive in order to receive services from **Preferred Care at Home**.
4. I understand that the terms of any Advance Directive that have been executed will be followed by **Preferred Care at Home** and its caregivers to the extent allowed by law.

**Please check off ONE appropriate selection and then sign below:**

I **HAVE** executed an Advance Directive.

Type:             Living Will     Durable Power of Attorney     Do Not Resuscitate (D.N.R.)

It is located: \_\_\_\_\_

I **HAVE NOT** executed an Advance Directive.

Comments: -

---



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## Section 4 : Going Home Checklist

### GOING HOME CHECKLIST

- Health-Care-Team Contact List
- Medication List, Reconciled
- Tests and Test-Results Chart
- Limitations, Restrictions and Special Care Instructions
- Medicaid Home and Community Based Services Assessment
- Medicare Home-health Services Assessment
- Private Home-Care Services Assessment
- Fall-Prevention Evaluation
- Medical Equipment Ordered
- Follow-Up Appointments Scheduled
- Transportation Scheduled
- Other : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### Section 5 : Health Care Team

Health-Care-Team Member	Name	Address	Phone Number
Patient			
Family Member (Spouse)			
Family Member (Son/Daughter)			
Family Member (Other)			
Primary Physician			
Specialist			
Specialist			
Specialist			
Hospitalist			
Hospital Nurses			
Hospital Case Managers			
Hospital Social Workers			
Discharge Planners			
Medicare Home-health Agency			
Therapists			
Home Health Agency Nurse			
Pharmacist/Pharmacy			
Private Home-Care Agency			
Medical-Equipment Company			
Medical Transportation (If Lift Needed)			
Home-Modification Contractor			
Other			











## Section 9 : Home Care Services

WHAT HOME CARE SERVICES WILL YOU NEED?

### MEDICAID AND OTHER NEED BASED or VA BENEFIT (Aid and Attendance)

Do you receive Medicaid services?  Yes  No

Do you receive any Home and Community Based Services?  Yes  No \_\_\_\_\_

If yes (to either question), which services?

Meals on Wheels

Home Care

Transportation

Other: \_\_\_\_\_

Are you a Veteran?  Yes  No

Are you eligible for the Aid and Attendance Benefit  Yes  No

Would you like information on the Aid and Attendance Benefit  Yes  No

### MEDICARE

Has your doctor ordered home health-care services?  Yes  No

Nursing (medical tasks like wound care)

Speech Therapy

Respiratory Therapy

Home-Health Aide

Occupational Therapy

Physical Therapy

Medical Social Worker

### PRIVATE HOME CARE

Has your doctor ordered other health-care services?  Yes  No

#### PERSONAL CARE

Bathing

Nail Care

Dressing

Changing Adult Diapers

Brushing teeth

Toileting

#### NUTRITION

Cooking

Assistance with eating



## Section 9 : Home Care Services *(continued)*

### PRIVATE HOME CARE *(continued)*

#### HOUSEHOLD CHORES AND ESCORT

- Cleaning
- Grocery Shopping
- Doing laundry
- Accompanying to doctor/clinic
- Accompanying to other locations

#### VITAL SIGNS

- Checking temperature
- Checking pulse
- Measuring blood pressure

#### ACTIVITIES

- Walking
- Transferring (such as moving from bed to chair)
- Exercising (simple range of motion)

#### OTHER SERVICES

- Medications assisting or reminding
- Ostomy care
- Assisting with nebulizer
- Assisting with dressing change for wound care
- Assisting with tube feeding
- Alzheimer's care
- Assisting with social interactions
- Other: \_\_\_\_\_



## Section 10 : Fall Prevention

### 4 Ways to Reduce Your Risk of Falls

#### EXERCISE

Are you on a regular exercise program?  Yes  No

Staying active is one of the most important ways to reduce your chance of falling. Regular exercise makes you stronger and helps you feel better. Exercise that improves balance and coordination (like tai chi) is the most helpful.

If yes, list activities: \_\_\_\_\_

If no, before starting an exercise program, consult with your doctor.

#### MEDICATION EVALUATION

Do you have an updated medication list?  Yes  No

Have your doctor or pharmacist look at all the medicines you take (including ones that don't need prescriptions, such as cold medicines). As you get older, the way some medications work in your body can change. Certain medicines, or combinations of medicines, can make you drowsy or light-headed, which can increase the risk of falling.

#### EYE EXAM

Have you had a recent eye exam?  Yes  No

Have your eyes checked by an eye doctor. You may be wearing the wrong glasses or have a condition such as glaucoma or cataracts that limits your vision. Poor vision can increase your chance of falling.

#### HOME SAFETY EVALUATION

Is your home safe?  Yes  No

About half of all falls happen at home. To make your home safer:

- Remove things you can trip over (such as papers, books, clothes, and shoes).
- Remove small throw rugs, or use double-sided tape to keep the rugs from slipping.
- Keep frequently used items within reach, to minimize use of a step stool.
- Have grab bars installed next to your toilet and in your tub or shower.
- Use nonslip mats in the bathtub and on shower floors.
- Improve your home lighting. As you get older, you need brighter lights to see well. Lampshades or frosted bulbs can reduce glare.
- Have handrails and lights installed on all staircases.
- Wear shoes that give support and have nonslip soles.



## Section 11 : Medical Equipment

### MEDICAL EQUIPMENT ASSESSMENT

Do you need special medical equipment or supplies?  Yes  No

If yes, what type of medical equipment? (Check all that apply)

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Catheter        | <input type="checkbox"/> Colostomy-care supplies | <input type="checkbox"/> Cane        |
| <input type="checkbox"/> Hoyer Lift      | <input type="checkbox"/> Oxygen                  | <input type="checkbox"/> Wheel Chair |
| <input type="checkbox"/> Hospital bed    | <input type="checkbox"/> IV setup                | <input type="checkbox"/> Walker      |
| <input type="checkbox"/> Bedside Commode | <input type="checkbox"/> Respirator              | <input type="checkbox"/> Other _____ |

Was this medical equipment ordered?  Yes  No

If yes, from where? \_\_\_\_\_

Telephone number: \_\_\_\_\_

Plans for delivery: \_\_\_\_\_

Special instructions: \_\_\_\_\_

Other notes (rental, co-pay, delivery): \_\_\_\_\_



## Section 12 : Follow-Up Appointments

### APPOINTMENTS

Do you have any follow-up appointments outside the home?  Yes  No

If yes, please answer these questions for each appointment:

#### Follow-Up Appointment:

Who is the appointment with? \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

What date is the appointment? \_\_\_\_\_

What time is the appointment? \_\_\_\_\_

Where is the appointment? \_\_\_\_\_

What is the telephone number for the appointment? \_\_\_\_\_

How will you get to the appointment? \_\_\_\_\_

Notes and Questions: \_\_\_\_\_

\_\_\_\_\_

#### Follow-Up Appointment:

Who is the appointment with? \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

What date is the appointment? \_\_\_\_\_

What time is the appointment? \_\_\_\_\_

Where is the appointment? \_\_\_\_\_

What is the telephone number for the appointment? \_\_\_\_\_

How will you get to the appointment? \_\_\_\_\_

Notes and Questions: \_\_\_\_\_

\_\_\_\_\_



**Section 12 :**  
**Follow-Up Appointments** *(continued)*

**APPOINTMENTS** *(continued)*

**Follow-Up Appointment:**

Who is the appointment with? \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

What date is the appointment? \_\_\_\_\_

What time is the appointment? \_\_\_\_\_

Where is the appointment? \_\_\_\_\_

What is the telephone number for the appointment? \_\_\_\_\_

How will you get to the appointment? \_\_\_\_\_

Notes and Questions: \_\_\_\_\_

\_\_\_\_\_

**Follow-Up Appointment:**

Who is the appointment with? \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

What date is the appointment? \_\_\_\_\_

What time is the appointment? \_\_\_\_\_

Where is the appointment? \_\_\_\_\_

What is the telephone number for the appointment? \_\_\_\_\_

How will you get to the appointment? \_\_\_\_\_

Notes and Questions: \_\_\_\_\_

\_\_\_\_\_



## Section 13 : Appointment Preparation

### APPOINTMENT PREPARATION

#### What to Ask

What is my problem? \_\_\_\_\_

What do I need to do? (Use Section 8) \_\_\_\_\_

Any referrals? (Use Section 5) \_\_\_\_\_

Any tests ordered? (Use Section 7) \_\_\_\_\_

Who do I call if problems come up? (Use Section 5) \_\_\_\_\_

Do I need a home-care referral? (Use Section 9) \_\_\_\_\_

#### What to Take

Take your completed Personal Health Record, or have an access code so your doctor can access it online. That's it!

Just a reminder: Make sure you've completed sections 1, 2, 4-8 and 10 of your Personal Health Record. This information will better equip your doctor to treat you.





## Section 14 : Goals

### GOALS

1. Something you want to do: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. How you'll do it: \_\_\_\_\_

Where: \_\_\_\_\_

What: \_\_\_\_\_

When / How often? \_\_\_\_\_

3. Barrier(s): \_\_\_\_\_

Plan to overcome barrier(s): \_\_\_\_\_







4. Are you convinced you can do this?

Indicate on the ruler below (1 = "totally unconvinced" and 5 = "very convinced")













## Section 15 : Emergency Plan

WHEN YOU HAVE:	CALL HOME HEALTH, HOSPICE or YOUR DOCTOR WHEN:	CALL 911 WHEN:
 <b>PAIN</b>	<ul style="list-style-type: none"> <li>You have new pain, OR your pain is worse than usual.</li> <li>You have an unusual bad headache.</li> <li>Your ears are ringing.</li> <li>Your blood pressure is above: ____/____.</li> <li>You have unusual low-back pain.</li> <li>You have pain or tightness of chest RELIEVED by rest or medication.</li> </ul>	<ul style="list-style-type: none"> <li>You have severe OR prolonged pain.</li> <li>You have a sudden severe unusual headache.</li> <li>You have pain/discomfort in neck, jaw, back, one or both arms, or stomach.</li> <li>You have chest discomfort with sweating/nausea.</li> <li>You have sudden chest pain or pressure, and medications don't help e.g. nitroglycerin as ordered by physician, OR</li> <li>Your chest pain went away and came back.</li> </ul>
 <b>TROUBLE BREATHING</b>	<ul style="list-style-type: none"> <li>Your cough is worse.</li> <li>It's harder to breathe when you lie flat.</li> <li>You have chest tightness RELIEVED by rest or medication.</li> <li>Your inhalers don't work.</li> <li>Your spit has changed color, thickness or odor.</li> </ul>	<ul style="list-style-type: none"> <li>You can't breathe!</li> <li>Your skin is gray OR fingers/lips are blue.</li> <li>You fainted.</li> <li>You have frothy spit.</li> </ul>
 <b>FEVER or CHILLS</b>	<ul style="list-style-type: none"> <li>You have fever above _____ °F.</li> <li>You have chills/can't get warm.</li> </ul>	<ul style="list-style-type: none"> <li>You have fever above _____ °F with chills, confusion or difficulty concentrating.</li> </ul>
 <b>FALLEN</b>	<ul style="list-style-type: none"> <li>You have dizziness or trouble with balance.</li> <li>You fell and hurt yourself.</li> <li>You fell but didn't hurt yourself.</li> </ul>	<ul style="list-style-type: none"> <li>You fell and have severe pain.</li> </ul>
 <b>TROUBLE MOVING</b>	<ul style="list-style-type: none"> <li>One of your arms or legs is sore.</li> <li>Your back is stiff / sore.</li> <li>You're walking slower.</li> </ul>	<ul style="list-style-type: none"> <li>Suddenly your face, arm or leg is weaker/numb/won't move.</li> <li>Suddenly one hand has a weaker grip or is dropping things.</li> <li>When you stick out your tongue, it's not in the middle of your mouth.</li> <li>When you smile, your mouth is uneven.</li> <li>When you raise your eyebrows, they're uneven.</li> <li>Your face is numb or drooping.</li> </ul>
 <b>BLOOD</b>	<ul style="list-style-type: none"> <li>You have bloody or cloudy urine, the color has changed, or it has a foul odor.</li> <li>Your gums, nose, mouth or surgical site is bleeding.</li> <li>You have unusual bruising.</li> </ul>	<ul style="list-style-type: none"> <li>Bleeding won't stop.</li> <li>Bleeding is accompanied by confusion, weakness, dizziness and fainting.</li> <li>You're throwing up bright-red blood, or it looks like coffee grounds.</li> <li>There's a large amount of bright red blood.</li> </ul>
 <b>TROUBLE THINKING</b>	<ul style="list-style-type: none"> <li>You're confused.</li> <li>You're restless, agitated.</li> <li>You can't concentrate.</li> </ul>	<ul style="list-style-type: none"> <li>You have sudden difficulty speaking.</li> <li>You're unable to remember important names (your own, spouse's, children's).</li> <li>Suddenly, you're unable to read. You can hear others talking but can't understand what they're saying.</li> </ul>
 <b>WEIGHT OR APPETITE CHANGE</b>	<ul style="list-style-type: none"> <li>You don't have an appetite.</li> <li>You lost ____ pounds in ____ days.</li> <li>You gained ____ pounds in 1 day OR ____ pounds in ____ days.</li> <li>Your feet/ankles/legs are swollen.</li> </ul>	



WHEN YOU HAVE:	CALL HOME HEALTH, HOSPICE or YOUR DOCTOR WHEN:	CALL 911 WHEN:
 <p><b>STRANGE SYMPTOMS</b></p>	<ul style="list-style-type: none"> <li>You're weaker than usual.</li> <li>You're dizzy, lightheaded, shaky.</li> <li>You're very tired.</li> <li>Your heart is fluttering, skipping or racing.</li> <li>Your vision is blurred.</li> </ul>	<ul style="list-style-type: none"> <li>You have sudden numbness or weakness of the face, arm or leg.</li> <li>You have sudden difficulty speaking/slurred words.</li> <li>You suddenly can't keep your balance.</li> </ul>
 <p><b>UPSET STOMACH</b></p>	<ul style="list-style-type: none"> <li>You're throwing up.</li> </ul>	<ul style="list-style-type: none"> <li>You can't stop throwing up.</li> <li>You're throwing up blood.</li> </ul>
 <p><b>BOWEL TROUBLES</b></p>	<ul style="list-style-type: none"> <li>You have diarrhea.</li> <li>You have a black/dark OR bloody bowel movement.</li> <li>You have no bowel movement in ____ days.</li> <li>You have no colostomy/ileostomy output in _____hours/days.</li> </ul>	
 <p><b>TROUBLE URINATING</b></p>	<ul style="list-style-type: none"> <li>Your catheter is leaking.</li> <li>There's no urine from catheter in ____ hours.</li> <li>You haven't passed water in ____ hours.</li> <li>Your urine is cloudy.</li> <li>You have a burning feeling while urinating.</li> <li>Your belly feels swollen or bloated.</li> </ul>	
 <p><b>ANXIETY or DEPRESSION</b></p>	<ul style="list-style-type: none"> <li>You're always feeling anxious</li> <li>You're unable to concentrate</li> <li>You feel a loss of hope.</li> <li>You have a loss of appetite.</li> <li>You have trouble sleeping.</li> <li>You feel constant sadness.</li> </ul>	<ul style="list-style-type: none"> <li>You have a plan of hurting yourself or someone else.</li> </ul>
 <p><b>WOUND CHANGES</b></p>	<ul style="list-style-type: none"> <li>There's a change in wound drainage amount, color or odor.</li> <li>Pain at wound site has increased.</li> <li>Redness/warmth at wound site has increased.</li> <li>You have a new skin problem.</li> <li>You have fever above _____°F</li> </ul>	<ul style="list-style-type: none"> <li>You have fever above _____ °F with chills, confusion or difficulty concentrating.</li> <li>Bleeding that won't stop.</li> </ul>
 <p><b>DIABETES or RELATED PROBLEMS</b></p>	<p>You have diabetes, and you're:</p> <ul style="list-style-type: none"> <li>Thirsty or hungry more than usual.</li> <li>Urinating a lot.</li> <li>Feeling weak.</li> <li>Having repeated blood sugar greater than _____mg/dl.</li> <li>Having repeated blood sugars less than _____mg/dl.</li> <li>Shaky.</li> <li>Extremely tired.</li> <li>Have a headache.</li> <li>Having trouble thinking, confusion or irritability.</li> </ul> <p>•Vision is blurred or different.</p> <p>•Experiencing dry and itchy skin.</p> <p>•Sweating.</p> <p>•Confused.</p> <p>•Experiencing a fast heart beat.</p> <p>Take: 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy.            Wait: 15 minutes and re-check blood sugar. IF it's still low and symptoms do not go away: eat a light snack:½ peanut-butter OR meat sandwich, plus ½ glass milk.            Wait: 15 minutes and re-check blood sugar.</p>	<p>You have diabetes and you have:</p> <ul style="list-style-type: none"> <li>Fruity breath.</li> <li>Nausea/vomiting.</li> <li>Difficulty breathing.</li> <li>Blood sugar greater than _____mg/dl.</li> <li>Low blood sugar not responding to treatment.</li> <li>Inability to treat low blood sugar at home.</li> <li>Unconsciousness.</li> <li>Seizures.</li> </ul>
 <p><b>OTHER PROBLEMS</b></p>	<ul style="list-style-type: none"> <li>Your Feeding Tube is clogged.</li> <li>You're having problems with your IV/site.</li> </ul>	<ul style="list-style-type: none"> <li>You've suddenly lost vision in one or both eyes.</li> </ul>

**P**referred Care at Home is a national senior home-care franchise whose number-one goal is to keep clients safe and sound in the comfort and security of where they prefer to be—home.

A wide range of services are provided, including: companionship, housekeeping, meal preparation, personal care, skilled care, medication reminders, accompanying to health-care appointments and much more. Preferred Care at Home's mission is to improve quality of life so much that independence and dignity is restored.

But besides these important services, Preferred Care at Home is also a connector for clients—connecting them with better organized and easily accessible personal health information for the entire health-care team. The ultimate goal is to minimize hospital readmissions, given that almost one-fifth of people on Medicare may be readmitted within 30 day after they leave, and up to 76 percent of those readmissions are preventable

Preferred Care at Home is committed to helping improve client outcomes by facilitating better communications for better care. Give us a call today at (866) 690-7733, and see how we can help be part of the solution.



Toll Free: 1-866-690-7733  
Email: [info@preferhome.com](mailto:info@preferhome.com)  
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