ABOUT MY LOVED ONE

Full name _____ Date of birth _____

Address _____ Phone _____

Preferred hospital _____ DNR on file? ☐ Yes ☐ No Kept at: _____

HEALTH CONDITIONS / DIAGNOSES

ALLERGIES

INSURANCE

Plan _____

Member ID _____

Group # _____

Phone _____

PHARMACY

Name _____

Phone _____

Address _____

LEGAL DOCUMENTS (WHERE THEY ARE KEPT)

Power of attorney _____

Health care proxy _____

Living will _____

Will _____

DAILY NEEDS AND PREFERENCES

MEDICATION LIST

MEDICATION	DOSE	WHEN	PRESCRIBED BY	FOR	START DATE

IMPORTANT CONTACTS

Name _____
Role _____
Phone _____
Email _____

Name _____
Role _____
Phone _____
Email _____

Name _____
Role _____
Phone _____
Email _____

Name _____
Role _____
Phone _____
Email _____

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IMPORTANT CONTACTS

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Name _____

Role _____

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Email _____

Name _____

Role _____

Phone _____

Email _____

QUESTIONS FOR THE DOCTOR

Questions for (name and title) _____

Best contacted by: ☐ In person ☐ Phone ☐ Email

1.	Answer
2.	Answer
3.	Answer
4.	Answer
5.	Answer

Questions for (name and title) _____

Best contacted by: ☐ In person ☐ Phone ☐ Email

1.	Answer
2.	Answer
3.	Answer
4.	Answer
5.	Answer

APPOINTMENT TRACKER

Date _____ **Time** _____ **Doctor** _____

Reason _____

Status: ☐ Declining ☐ Stable ☐ Improving

Tests ordered _____ **Results** _____

Notes

_____

Date _____ **Time** _____ **Doctor** _____

Reason _____

Status: ☐ Declining ☐ Stable ☐ Improving

Tests ordered _____ **Results** _____

Notes

_____

Date _____ **Time** _____ **Doctor** _____

Reason _____

Status: ☐ Declining ☐ Stable ☐ Improving

Tests ordered _____ **Results** _____

Notes

_____

Date _____ **Time** _____ **Doctor** _____

Reason _____

Status: ☐ Declining ☐ Stable ☐ Improving

Tests ordered _____ **Results** _____

Notes

_____

ER & HOSPITAL VISITS

Date _____ Time _____ Hospital / ER _____

Why we went _____

What they did / diagnosis _____

Medications started, stopped or changed _____

Follow-up / discharge instructions _____

_____

Date _____ Time _____ Hospital / ER _____

Why we went _____

What they did / diagnosis _____

Medications started, stopped or changed _____

Follow-up / discharge instructions _____

_____

Date _____ Time _____ Hospital / ER _____

Why we went _____

What they did / diagnosis _____

Medications started, stopped or changed _____

Follow-up / discharge instructions _____

_____

MEDICAL EXPENSES LOG

DATE OF SERVICE	DESCRIPTION	PROVIDER	AMOUNT	PAID BY INSURANCE	BALANCE DUE	DUE DATE	STATUS

Every day you show up is a choice. Today, you chose love.

Day _____ Date _____ ☐ Appointment today

TODAY'S GOAL

_____

_____

_____

_____

TO-DO LIST

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

BLOOD PRESSURE	PULSE	BLOOD SUGAR	TEMP	OXYGEN	WEIGHT

MEDICATION	AMOUNT	TIMES GIVEN						SIDE EFFECTS / NOTES
1.								
2.								
3.								
4.								
5.								

MEALS & FLUIDS

Breakfast	Lunch	Dinner	Snacks / fluids

ACTIVITY / EXERCISE

_____

_____

_____

_____

PROBLEM	ACTION STEPS

END OF THE DAY

How did today feel? (1 = terrible, 5 = great) (1) (2) (3) (4) (5)

I felt this way because _____

The best thing that happened today _____

One thing I did for me today _____