

## Health Care Information

		DEDSO	NAI I	NFORMATION			
First Name		(Nickname)		Last Name		DOB or Age	
i iist Ivailie		(MORHAINE)		Lastitatio		DOD OF Ago	
Street Address				City, State, ZIP			
Preferred Language Phone Number			Emergency Contact Information				
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Descrit and Democratetics				Parant/Logal Panrocentative Phone/Email			
Parent/Legal Representative				Parent/Legal Representative Phone/Email			
Insurance Information				Pharmacy Information (most commonly used)			
Primary Care Provider/Cor	ntact Inform	ation		Specialty Care Providers/Contact Information			
Communication Support Needed							
Communication Support Needed							
						_	
Current Symptoms  Note: Information on this form may not be complete							
Symptom	When	it started			-	,	
☐ Fever - Temp:				Medic	cation List		
☐ Cough							
☐ Muscle Pain/Fatigue							
☐ Shortness of Breath							
☐ Chest Pain/Pressure							
☐ Blue Lips/Face							
☐ Nasal Congestion				Allergies and	Diotary Bost	rictions	
☐ Diarrhea				Allergies and	Dietary Rest	rictions	
☐ Loss of Smell/Taste							
<ul><li>☐ Sore Throat</li><li>☐ Blood Oxygen &lt;90</li></ul>							
☐ Headache							
☐ Confusion/Won't Wake				Medical/Assistive Devi	ces and/or S	ervice Animal	
☐ Body Ache							
☐ Chills/Shaking with Chill	s						
☐ Other:							
	<u> </u>						
Check all that apply							
☐ Neurodevelopmental disord	der/ID	Kidney disease		Immunocompromised	☐ Smoker		
□ Cancer		Liver disease		Severe obesity (>40 BMI)	☐ Homeless		
□ COPD		Heart disease		Mental illness Substance use		care resident	
□ Emphysema □ Asthma		HIV/AIDS Diabetes	_	Corticosteroid use	☐ Pregnant ☐ Age 65 or 6	older	
_ /	_	Diapotoc	_		_ / igo 00 0.	J1401	
Other Health Conditions							
Advance Care Planning (check all that apply)							
☐ HEALTH CARE ADVANCE DIRECTIVE OR LIVING WILL – Location, if known:							
□ POWER OF ATTORNEY– Location, if known:							
☐ DO NOT RESUSCITATE (	NR) ORDEF	R – Location, if know	wn:				

☐ PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST OR POST)

☐ PSYCHIATRIC ADVANCE DIRECTIVE – Location, if known:

Health Care Person-Centered Profile What Matters to Me	e 
Please call me	<u>I</u>
1. What we also convenients about we	
1. What people appreciate about me	
2. Who and what is important to me	
3. How to best support me	
This Health Care Person-Centered Profile was completed by:   Me Someone else Name and relationship)	



