

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 | | | | |
| | | | | 5 , | | | |
| 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 | | | | | | | |
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| | | | | | | _ | |
| 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 | | | | | | | |
| ☐ Sore Throat☐ Blood Oxygen <90 | | | | | | | |
| ☐ 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) | |



