HOW TO WORK WITH YOUR
PERSONAL HEALTH RECORD

PURPOSE OF THE PERSONAL HEALTH RECORD

The primary purpose of the **Personal Health Record** is to provide persons diagnosed with dementia and their caregivers with as complete a record as possible so that they are saved the necessity of repeating the same information at each stage involved in accessing needed services.

It is designed:

- to present the information most frequently required by service agencies in a convenient format
- to provide in one location contact information that may be needed by the caregiver
- to inform the various agencies of all parties involved in providing service

INFORMATION THAT SHOULD BE RECORDED

The **Personal Health Record** should be started as soon as a diagnosis is made. Even though this may seem unnecessary at the time, important details that may be required at later stages can all too readily be forgotten. It is much easier to obtain a complete record if information is noted from the initial assessment stages.

FORMAT OF THE PERSONAL HEALTH RECORD

You may wish to keep your **Personal Health Record** in a binder to allow for removal and addition of pages as needed. The number of pages required for each section will vary from person to person. For those with computer access, additional pages can be downloaded from the Alzheimer Society of Ottawa and Renfrew County website. Otherwise feel free to duplicate any pages as required.

The main body of the **Personal Health Record** consists of five sections:

1. <u>General Information</u> - for important contact numbers and personal background information most frequently requested by service agencies.

2. <u>Medical History to Date</u> - for recording the key medical events in the person's life, with dates where possible. Family doctors may be able to provide this information when no previous personal records are available

.../2

HOW TO WORK WITH YOUR PERSONAL HEALTH RECORD cont'd:

3. Medications - for reporting all current medications, both prescription and non-prescription. Record only those past medications to which there has been an allergic or adverse reaction. Because dosages may change frequently, these should not be recorded here. Service agencies will only be interested in the current dosage, and may ask that the medications accompany the person to an appointment. Alternatively, a note with the current dosages could be made for specific appointments and clipped on the Medications section.

4. Community Services - for keeping track of the various agencies contacted as the need arises, the name and phone number of the contact person in each agency, and any relevant notes on the purpose or outcome of the contact.

5. Personal Notes - for recording other contact names and numbers pertinent to the caregiver but not generally required by service agencies, so that this information is readily accessible to the caregiver when needed. Suggested topics are provided at the beginning of the section.

INFORMATION THAT SHOULD NOT BE RECORDED

Some caregivers may wish to record more detailed information about daily needs and activities for their own personal reference. This kind of information would add greatly to the volume of the **Personal Health Record**, and is not normally required by service agencies. It is recommended that the *Personal Care* booklet, available from the Alzheimer Society, be looked at as a resource for such detailed recording. Once again, the primary purpose of the **Personal Health Record** is to provide as succinctly and clearly as possible, the kind of information required by service agencies when the need for their services arises, and secondarily, to provide in one location any other relevant contact information that may be needed by the caregiver.

USING THE PERSONAL HEALTH RECORD

Please take the **Personal Health Record** to all doctor and other health care appointments, so that up-to-date information is readily available for these consultations.