Champlain Dementia Network
Réseau de la démence de la région Champlain

PERSONAL HEALTH RECORD

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FOR _____

This document is provided for your use.

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

Champlain Dementia Network
Réseau de la démence de la région Champlain

This resource has been prepared by the Service Delivery Committee of Champlain Dementia Network.

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Ce document est également disponible en français.

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GENERAL INFORMATION

Name: _____
Address: _____
_____
Phone Number: _____
Email: _____
Lives Alone: _____Yes _____ No

Preferred Name/Nickname: _____
Birth Date: _____
OHIP Number: _____
Social Insurance Number: _____
Veteran Registration Number: _____
Ontario Drug Benefit Number: _____

PRIMARY CAREGIVER

Name: _____
Address: _____
_____
_____

Relationship: _____
Phone Numbers: _____
_____

POWER OF ATTORNEY FOR PERSONAL CARE

Name: _____
Address: _____
_____
_____

Relationship: _____
Phone Numbers: _____
_____

POWER OF ATTORNEY FOR PROPERTY

Name: _____
Address: _____
_____
_____

Relationship: _____
Phone Numbers: _____
_____

OTHER CONTACTS IN EMERGENCY

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Numbers: _____ Phone Numbers: _____

FAMILY DOCTOR

Name:_____

Address:_____

Phone Number: _____

DENTIST

Name: _____

Address: _____

Phone Number: _____

EYE CARE SPECIALIST

Name: _____

Address: _____

Phone Number: _____

PHARMACY Name: _____ Phone Number: _____

SPECIALIZED MEDICAL SERVICES FOR DEMENTIA

Check (✓) to indicate where you have had an assessment or follow-up

Type of Service	Location	Date First Seen	By Whom	Diagnosis
☐ Geriatric Assessment Unit				
☐ Geriatric Day Hospital				
☐ Geriatric Psychiatry				
☐ Memory Disorder Clinic				
☐ Mental Health				
☐ Parkinson's & Neurodegenerative Disorders Clinic				
☐ Other (Please specify) _____				

OTHER MEDICAL SPECIALISTS (e.g., for arthritis, heart, cancer, etc)

Name: _____ Name: _____ Name: _____
Specialty: _____ Specialty: _____ Specialty: _____
Address: _____ Address: _____ Address: _____
Phone Number: _____ Phone Number: _____ Phone Number: _____

Name: _____ Name: _____ Name: _____
Specialty: _____ Specialty: _____ Specialty: _____
Address: _____ Address: _____ Address: _____
Phone Number: _____ Phone Number: _____ Phone Number: _____

SUPPLEMENTAL HEALTH INSURANCE (e.g., Public Service Health Care Plan, Blue Cross, etc.)

Company: _____ Policy Number: _____
Telephone Contact: _____

DENTAL INSURANCE

Company: _____ Policy Number: _____
Telephone Contact: _____

LONG TERM CARE INSURANCE

Company: _____ Policy Number: _____
Telephone Contact: _____

SAFELY HOME™ PROGRAM (WANDERING REGISTRY)

Identification Number _____

MEDICAL HISTORY TO DATE

Blood Type: _____

Allergies: (include medications, such as aspirin; food such as peanut butter; and environmental, such as smoke, dust, pollen)

_____

_____

Date	Major Illnesses/Diagnoses	Surgeries	Tests/Scans	Location

Medical History cont'd:

Date	Major Illnesses/Diagnoses	Surgeries	Tests/Scans	Location

Medical History cont'd:

Date	Major Illnesses/Diagnoses	Surgeries	Tests/Scans	Location

Medical History cont'd:

Date	Major Illnesses/Diagnoses	Surgeries	Tests/Scans	Location

MEDICATIONS

MedicAlert Registration _____

Medication Allergies: _____

_____

_____

- Include prescription and non-prescription medications such as vitamins, herbal remedies, and any allergy medication.
- List current medication only, except for those medications which in the past have caused an allergic or adverse reaction.

Date	Prescribed By	Name of Medications	Date Discontinued	Why Discontinued

Medications cont'd:

Date	Prescribed By	Name of Medications	Date Discontinued	Why Discontinued

Medications cont'd:

Date	Prescribed By	Name of Medications	Date Discontinued	Why Discontinued

Medications cont'd:

Date	Prescribed By	Name of Medications	Date Discontinued	Why Discontinued

COMMUNITY SERVICES

Check (✓) to indicate the services with which you have had contact (and list the contact person or case manager):

- ☐ Alzheimer Society — Contact person: _____
- ☐ Community Care Access Centre (CCAC) — Case manager: _____
  - ☐ CCAC accessed Day Programs
  - ☐ CCAC accessed Home Care
  - ☐ CCAC accessed Occupational Therapy
  - ☐ CCAC accessed Physiotherapy
  - ☐ CCAC accessed Short Term Respite
  - ☐ CCAC accessed Nursing Services
- ☐ Family Paid Home Care — Contact person: _____
- ☐ First Link™ Program — Contact person: _____
- ☐ Geriatric Psychiatry — Contact person: _____
- ☐ Meals on Wheels — Contact person: _____
- ☐ Mental Health — Contact person: _____
- ☐ Private Short Term Respite — Contact person: _____
- ☐ Seniors' Centres — Contact person: _____
- ☐ Other (please specify) _____ — Contact person: _____

Community Services cont'd:

Date	Community Service Agency	Seen By	Telephone Number	Purpose and Outcome

Community Services cont'd:

Date	Community Service Agency	Seen By	Telephone Number	Purpose and Outcome

Community Service cont'd:

Date	Community Service Agency	Seen By	Telephone Number	Purpose and Outcome

PERSONAL NOTES

This section is provided to record other information that the caregiver would like to have readily available for reference. Suggested topics to include in this section are as follow:

- ✓ Therapy contacts such as physiotherapy, chiropractic
- ✓ Long Term Care notes
- ✓ Advance Directives or Living Will details
- ✓ Whether or not a DO NOT RESUSCITATE (DNR) order should be placed if hospitalized
- ✓ Funeral Home arrangements

PERSONAL NOTES

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