Healthcare Management Binder

Patient's Journal

2019 EDITION

THIS DOCUMENT HAS BEEN MADE POSSIBLE BY AN UNRESTRICTED GRANT FROM ACTELION PHARMACEUTICALS CANADA INC.

PERSONAL INFORMATION

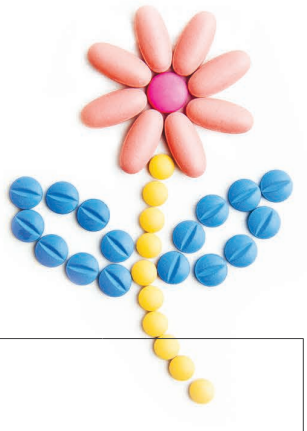
NAME:			GENDER:	
			Male	Female
ADDRESS:			HEALTH INSURANCE # :	
PROVINCE:			DATE OF BIRTH:	PLACE OF BIRTH:
			YR-MM-DAY	
TELEPHONE (HOME):	TELEPHONE (WORK) :	TELEPHONE (CELL) :	ORGAN DONOR:	
			YES	NO
PRIMARY CARE PHYSICIAN :		TELEPHONE:	BLOOD TYPE :	
EMERGENCY CONTACT NAME:				
TELEPHONE:		RELATIONSHIP :	MEDICAL CONDITION :	
EMERGENCY CONTACT ADDRESS:				
TELEPHONE Nº 2 :				
EMERGENCY CONTACT NAME:			DRUG ALLERGIES :	
TELEPHONE :		RELATIONSHIP :		
EMERGENCY CONTACT ADDRESS:			FOOD OR ENVIRONMENTAL ALLERGIES:	
TELEPHONE Nº 2 :				

EMPLOYMENT INFORMATION

EMPLOYER:	STUDENT:	YES	NO
	EMPLOYER'S PHONE:		
ADDRESS:	JOB DESCRIPTION:		

INSURANCE INFORMATION	
PRIMARY INSURANCE COMPANY:	
ADDRESS:	POLICY #:
TELEPHONE:	GROUP #:
NAME OF POLICY HOLDER:	RELATIONSHIP:
SECONDARY INSURANCE COMPANY:	
ADDRESS:	POLICY #:
TELEPHONE:	GROUP #:
NAME OF POLICY HOLDER:	RELATIONSHIP:
DRUG INSURANCE #:	HOSPITAL ID CARD #:
COMMENTS:	

CURRENT MEDICATIONS

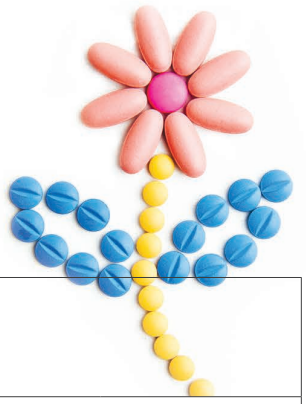


Pharmacy #1:	PHONE #:
Pharmacy #2:	PHONE #:

MEDICATION RECORD					
MEDICATION'S NAME & STRENGTH	DOSAGE	TIME(S)	# TIMES/DAY	DATE STARTED	REASON FOR TAKING

COMMENTS:

CURRENT MEDICATIONS *(cont.)*

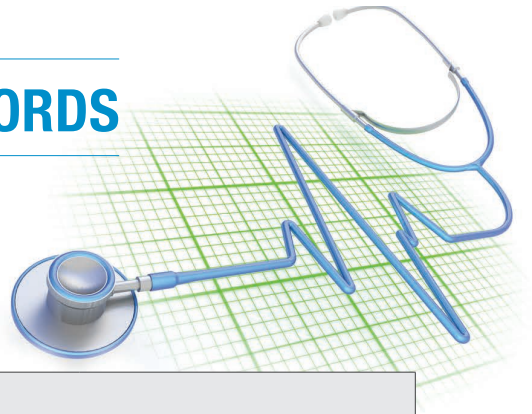


Pharmacy #1:	PHONE #:
Pharmacy #2:	PHONE #:

MEDICATION RECORD					
MEDICATION'S NAME & STRENGTH	DOSAGE	TIME(S)	# TIMES/DAY	DATE STARTED	REASON FOR TAKING

COMMENTS:

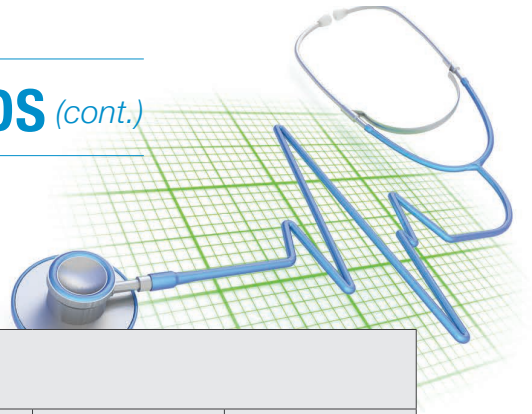
CARDIOPULMONARY RECORDS



ECHOCARDIOGRAM			
DATE	LOCATION	FINDINGS	RECORD OBTAINED

PULMONARY FUNCTION TESTS (PFT)		
DATE	LOCATION	FINDINGS

CARDIOPULMONARYRECORDS *(cont.)*



BLOOD PRESSURE RECORD						
DATE	TIME	POSITION (E.G. SITTING)	ARM R OR L	LOCATION	READING	PULSE

GL SYMPTOM TRACKER

SYMPTOM	DATE	TIME	TREATMENT	COMMENTS

COMMENTS:

WEIGHT RECORD

DATE	WEIGHT	TIME OF DAY	SPECIAL DIET / COMMENTS

COMMENTS:

DENTAL EXAM RECORD

NAME OF DENTIST:	ADDRESS:
PHONE #:	COMMENTS:

PRIMARY DENTAL INSURANCE	
ADDRESS:	PHONE #:
	POLICY #:
	GROUP # :
NAME OF POLICY HOLDER:	RELATIONSHIP:

DRY MOUTH				
DATE	NAME OF DENTIST	DRY MOUTH	FINDINGS	COMPLICATIONS / COMMENTS/ TREATMENT

DENTAL EXAM RECORD

DATE	NAME OF DENTIST	CLEANING	EXAM	FLUORIDE	X-RAY	FOLLOW-UP	COMMENTS

COMMENTS:

DIAGNOSTIC TESTS / BLOOD WORK

DATE	LOCATION	TYPE OF TEST	REASON	RECORDS RECEIVED	
				YES	NO
COMMENTS:					

DIAGNOSTIC TESTS / BLOOD WORK *(cont.)*

DATE	LOCATION	TYPE OF TEST	REASON	RECORDS RECEIVED	
				YES	NO

COMMENTS:

HISTORY OF HOSPITALIZATIONS AND SURGERIES

HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED
PHONE #:		INPATIENT/OUTPATIENT	
REASON FOR HOSPITALIZATION/ TYPE OF SURGERY:			
ADDRESS:		PHYSICIAN'S/SURGEON'S NAME:	
COMPLICATIONS:			

HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED
PHONE #:		INPATIENT/OUTPATIENT	
REASON FOR HOSPITALIZATION/ TYPE OF SURGERY:			
ADDRESS:		PHYSICIAN'S/SURGEON'S NAME:	
COMPLICATIONS:			
COMMENTS:			

HISTORY OF HOSPITALIZATIONS AND SURGERIES *(Cont.)*

HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED
PHONE #:		INPATIENT/OUTPATIENT	
REASON FOR HOSPITALIZATION/ TYPE OF SURGERY:			
ADDRESS:		PHYSICIAN'S/SURGEON'S NAME:	
COMPLICATIONS:			

HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED
PHONE #:		INPATIENT/OUTPATIENT	
REASON FOR HOSPITALIZATION/ TYPE OF SURGERY:			
ADDRESS:		PHYSICIAN'S/SURGEON'S NAME:	
COMPLICATIONS:			
COMMENTS:			

OPTOMETRY / OPHTHALMOLOGY TREATMENT RECORD

DATE	PHYSICIAN'S NAME	REASON FOR VISIT	COMMENTS

SPECIALIST VISITS

Scleroderma patients experience a broad spectrum of symptom manifestations. These medical issues cause there to be a need to visit a number of healthcare professionals. Please use this page to record visit to specialists sush as: Rheumatologists, Pneumologists, Cardiologists, Gastroenterologists, Dermatologists, Nephrologists, Vascular Surgeons, etc.

DATE	NAME/TYPE OF SPECIALIST	REASON FOR VISIT	DIAGNOSIS	RECOMMENDED TREATMENT
COMMENTS:				

SPECIALIST VISITS *(Cont.)*

DATE	NAME/TYPE OF SPECIALIST	REASON FOR VISIT	DIAGNOSIS	RECOMMENDED TREATMENT

COMMENTS:

RAYNAUD'S PHENOMENON

(Discoloration and sensation of numbness of the fingers or toes triggered by cold or stress)

SYMPTOMS SEVERITY SCALE 1 (SLIGHT) TO 10 (SEVERE)	FREQUENCY: DATE, TIME, DURATION	PROTECTIVE MEASURES AGAINST COLD AND STRESS	MEDICATION OR TREATMENT	CAPILLAROSCOPY/ DATE
COMMENTS:				

DIGITAL ULCERS (DU)

(Open and painful sores on the finger/toe tips requiring time to heal)

SYMPTOMS	DATE	PROTECTIVE MEASURES	MEDICATION OR TREATMENT
COMMENTS:			

SPECIALISTS' LIST

NAME	ADDRESS	TELEPHONE

LEGAL DOCUMENTS (ORIGINALS)

- **Living Will –** A document where the patient can describe any life-sustaining treatment he/she may want prior to the patient being unable to make these decisions.
- **Health Care Power of Attorney –** This is a legal document where the patient gives another person the power to make decisions about the patient's medical care if the patient is no longer able to communicate.
- **Do Not Resuscitate form –** Intended to help people in the final stages of terminal illness or who suffer from a serious condition. It informs healthcare professionals to forgo resuscitation attempts such as, CPR, intubation, defibrillation, administration of certain drug, etc.
- **DNR (Do Not Resuscitate) Directive –** A form in which a patient stipulates that no extraordinary measures are to be used.
- **DNR Order -** A physician's order on the chart stating that extraordinary measures are not to be used in an attempt to save a patient's life.
- **Birth Certificate**
- **Release(s) for Medical Information**

It is strongly recommended to consult a lawyer or a notary to learn more about required documents or other documents that may be relevant based on your personal situation.

DISCLAIMER

Because the manifestations and severity of scleroderma vary among individuals, personalized medical management is essential. The Scleroderma Society of Canada and Sclérodermie Québec have created the medical management binder as a tool and strongly recommends all treatments be discussed with the patients' physician(s) for proper evaluation and treatment recommendations.

SCLÉRODERMIE QUÉBEC

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info@sclerodermie.ca

OUR MISSION

SUPPORT

Help people with scleroderma
by providing moral and medical support.

RESEARCH

Raise funds for scleroderma research.
Stimulate and support financially research
aimed at defeating scleroderma.

INFORMATION

Develop information tools for the public and
stakeholders in the medical community.

Scleroderma™

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Email: info@sclerodermie.ca

sclerodermafoundation.ca
Charitable Registration Number 89808 9693 RR0001

DONATION FORM

Name:	Date:	
Address:		
City:	Province:	Postal Code:
Phone:	Email:	

❑ I have been diagnosed with scleroderma*
❑ I am a relative of a person diagnosed with scleroderma*
*information will be kept strictly confidential

❑ I would like to subscribe to Scleroderma Quebec's **Le BULLETIN**
❑ I want a tax receipt

Donation Amount: ❑ $200 ❑ $100 ❑ $50 ❑ $25 Other: $

❑ Cheque (Payable to Scleroderma Quebec)

❑ Visa ❑ Mastercard Credit Card Number: Expiration Date: (_____/_____)

Name as it appears on credit card: Signature:

Note: For credit card payments please return your form by fax to 514-666-1639 or by mail to the adress mentionned above.

If your donation is in memory or in honour of a special person, please complete the section below.

❑ In memory of:

❑ In honour of:

❑ Person to be notified (a card with your name will be sent to him/her acknowledging your kind gift):

Address:

❑ I would like more information on how to make a testamentary bequest to Scleroderma Quebec

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