Remote Support

This document has information to help support me when I am in your care.

READ THIS BEFORE assisting me with care or providing treatment.

My Information

Name: _____________________________________ DOB: _____________________________

Address:____

Insurance info:____

Primary Care Physician:

Name: _________________________________ Phone__________________________________

Address____

Primary Emergency Contact:

Name: ___________________________________ Phone: _________________________________

Family Contact:

Name: ___________________________________ Phone: ___________________________________

Provider Contact:

Name: ___________________________________ Phone: ___________________________________

Allergies:

__________________________ __________________________ __________________________

Diagnoses:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Wound Care (if applicable: area, dressing, etc.)

Current List of Medications:

Communicating with Me:

I communicate by: (words, ASL, gestures -describe, behaviors-describe)

Best way to communicate with me is:

When I like something, I (explain)

When I dislike something (explain)

When I am upset, I:

Best way to help me calm myself:

Sensitivities (light, sound, odor, etc.)

I exhibit pain by (describe behavior or verbal cues):

I take medications best (Liquids, pills, mixed in applesauce/pudding):

Pain can be best managed by (PRN medications, distractions, repositioning)

My Vision (normal, require glasses, blind, impaired):

My Hearing (normal, require aids, deaf)

My Level of Mobility: (describe method, gait, equipment)

Toileting: (Continence level, assistance needed, bedside toilet)

Mealtime Assistance:

Diet (type and texture):

Positioning:

Assistance needed for eating:

Assistance needed for drinking:

Adaptive equipment needed (nosey cup, utensils, weighted spoon or plate)**:**