HEALTHCARE DOCUMENTS

"TO GO" PACKET

THE DOCUMENTS CONTAINED IN THIS PACKET ARE FOR YOUR EXCLUSIVE USE IN COLLECTING YOUR HEALTH INFORMATION AND HAVING IT AVAILABLE IN ONE EASILY-ACCESSIBLE LOCATION. THIS COLLECTED INFORMATON WILL THEN BE READILY AVAILABLE FOR USE BY YOU, BY DESIGNATED FAMILY MEMBERS OR OTHER APPROVED PROVIDERS INVOLVED IN YOUR HEALTHCARE.

MEDICAL INFORMATION / DOCUMENTS

For: _____

Date: _____

"To Go" Medical Information/Documentation

The following documents are included in this folder:

_____ My Personal Health Record: My Medical History

- Includes Emergency Contacts' Information

_____ My Personal Medication Information

_____ My Medication / Food Allergies

- Additional information on specific allergies

_____ Copy of insurance card(s) and co-pays

_____ Photo identification

_____ Military Discharge Document – DD Form 214

Legal Documents:

_____ Advance Directive for Health Care
_____ Physician Orders for Scope of Treatment (or Life-sustaining Treatment) – POST or POLST
_____ Durable Power of Attorney for Healthcare (POA)
_____ Living Will
_____ DNR (Do Not Resuscitate)
_____ DNI (Do Not Intubate)

Provided by "Supporting Aging with Choices" Vision Council
For information: Frontdesk@uwaykpt.org or 423-378-3409, ext. 10

United Way of Greater Kingsport

MY PERSONAL HEALTH RECORD

For _____ **Date** _____

My Power of Attorney for Healthcare (POA): _____ _____
Name Phone Number

My Emergency Contacts:

Name	Relationship	Phone Number

My Healthcare Providers:

Name	Address	Phone Number

Significant Illnesses (with dates):

Illness	Date of onset	Duration

Surgical procedures (with dates):

Surgical Procedure	Date of procedure

Important test results (with dates):

Test Result	Date of Test

Immunization records (with dates):

Immunizations	Dates

Hereditary health conditions in my family history:

Health condition	Family member	Additional information on condition

Are you a veteran? _____ Do you have access to military benefits? _____ If so, what are the specifics of those benefits and where do you receive them? _____

_____

MY PERSONAL MEDICATION INFORMATION for _____ **Date** _____

	Name of Medication	Description	Dosage	Time to Take	Start/Stop Dates	Medication is For:	Prescribed By:
1							
2							
3							
4							
5							
6							
7							
8							
9							

ALLERGIES: _____ _____ _____ _____

_____ _____ _____

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MY MEDICATION / FOOD ALLERGIES

For: _____ **Date:** _____

Do you carry a prescription "Epinephrine Injection" (EpiPen) with you? _____

Known Allergen:	Hypersensitivity or Verified Allergy:	Adverse Reaction:
Prescription Medications		
Environmental / Food		

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MEDICAL / HEALTH INSURANCE CARDS

COPIES of ACTIVE INSURANCE CARDS (including Long-term Care)

For _____

Date _____

Health Insurance Information (including Long-Term Care Insurance):

Insurance Company	Insurance Number	Phone Number

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United Way of Greater Kingsport

Photo Identification

For_____

Date_____

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1 **Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 **Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

_____

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometime called "POLST")

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ Resuscitate (CPR) ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatment.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

Section C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

Section D *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature** **Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:** ( )

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your agent/surrogate.

Name (Print)	Signature	Relationship (write "self" if patient)	
Agent/Surrogate	Relationship	Phone Number ( )	
Health Care Professional Preparing Form	Preparer Title	Phone Number ( )	Date Prepared

Notes

Grab & Go list

___ Pair of Glasses

___ Change of Clothes

___ Pair of Shoes

___ Robe

___ Hairbrush

___ Comb

___ Toothbrush

___ Toothpaste

___ Mirror

___ Make-Up

___ Books/Maazines

___ Notepad & Pen

___ Money for Vending Machines

___ Phone & Phone Charge

___ Ipod, Ipad or tablet and “ear buds”