

Healthcare Management Binder

Patient's Journal

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PERSONAL INFORMATION

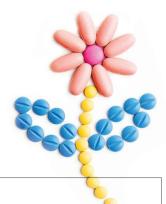
NAME:			GENDER:		
				Male	Female
ADDRESS:				HEALTH INS	URANCE #:
PROVINCE:				DATE OF BIRTH:	PLACE OF BIRTH:
				YR-MM-DAY	
TELEPHONE (HOME):	TELEPHONE (WORK):	TELEPHONE (CELL):	ORGAN	DONOR:
				YES	NO
PRIMARY CARE PHYSICIAN	1:	TE	ELEPHONE:	BLOOD	TYPE:
EMERGENCY CONTACT NA	ME:				
TELEPHONE:		R	ELATIONSHIP :	MEDICAL C	ONDITION:
	ADDEOO.				
EMERGENCY CONTACT AD	DURESS:				
TELEPHONE N° 2 :					
EMERGENCY CONTACT NA	ME:			DRUG AL	LERGIES:
TELEPHONE :		R	ELATIONSHIP :		
EMERGENCY CONTACT AD	DRESS:				/IRONMENTAL RGIES:
TELEPHONE N° 2 :					



EMPLOYER:		STUDENT:	YES	NO		
			EMPLOYER'S PHONE:			
ADDRESS:		JOB DESCRIPT	ΠΟΝ:			
INSURANCE	INFOR	MATION				
PRIMARY INSURANCE COMPANY:						
ADDRESS:	POLI	CY #:				
TELEPHONE:	GRO	 UP #:				
TEEL HONE.	ano	Οι π.				
NAME OF POLICY HOLDER:	RELA	TIONSHIP:				
SECONDARY INSURANCE COMPANY:						
ADDRESS:	POLI	CY #:				
ABBILLOO.	I OLI	O 1 11.				
TELEPHONE:	GRO	UP#:				
NAME OF POLICY HOLDER:	RELA	TIONSHIP:				
DRUG INSURANCE #:	HOSI	PITAL ID CARD #	<u>:</u> :			
COMMENTS:						



CURRENT MEDICATIONS



Pharmacy #1:			PHONE #:		6
Pharmacy #2:			PHONE #:		
		MEDICATION REC	CORD		
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 REC	CORD		
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:				

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WEIGHT RECORD

DATE	WEIGHT	TIME OF DAY	SPECIAL DIET / COMMENTS
COMMENTS:			

DENTAL EXAM RECORD

NAME OF DE	NTIST:		ADDRESS:				
PHONE #:			COMMENTS:				
PRIMARY DENTAL INSURANCE							
ADDRESS:			PHONE #:				
			POLICY #:				
			GROUP #:				
NAME OF POI	LICY HOLDER:		RELATIONSHI	P:			
		DRY MOU	JTH				
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		REASON	RECORDS RECEIVE	
				YES	NO
COMMENTS:					

DIAGNOSTIC TESTS / BLOOD WORK (cont.)



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

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/ TY	PE OF SURGERY:						
ADDRESS:	Pi	HYSICIAN'S/SURGEON'S NAMI	<u> </u>				
COMPLICATIONS:	'						
COMMENTS:							
COMMENTO.							

HISTORY OF HOSPITALIZATIONS AND SURGERIES (Cont.)

HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED		
PHONE #:		INPATIENT/OUTPATIENT			
REASON FOR HOSPITALIZATION/ TY	PE OF SURGERY:				
ADDRESS:	PI	PHYSICIAN'S/SURGEON'S NAME:			
COMPLICATIONS:					
HOSPITAL	DATE ADMITTED	DATE OF SURGERY	DATE DISCHARGED		
PHONE #:		INPATIENT/OUTPATIENT			
REASON FOR HOSPITALIZATION/ TY	PE OF SURGERY:				
ADDRESS:	PI	HYSICIAN'S/SURGEON'S NAM	≣:		
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
	01 2011 (210 1			TREATMENT
COMMENTS	· •			

SPECIALIST VISITS (Cont.)

DATE	NAME/TYPE OF SPECIALIST	REASON FOR VISIT	DIAGNOSIS	RECOMMENDED TREATMENT
COMMENTS	: 3:		I	

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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:				
COMMITTIO.				

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 lifesustaining 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 Scleroderma Manitoba 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.



SCLERODERMA MANITOBA

22 Silverdale Crescent Winnipeg MB R2N 1B1 Phone: 204-417-6017

www.sclerodermamanitoba.com info@sclerodermamanitoba.com

OUR MISSION

Working on several fronts, Scleroderma Manitoba has a three-fold mission:



Supporting scleroderma patients by promoting patient outreach and education.

RESEARCH



Encourage and support leading edge research in Manitoba and Canada.

INFORMATION



Raising public awareness and developing information tools for the general public and stakeholders in the medical community.



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sclerodermamanitoba.com Charitable Registration Number 861033819RR0001

DONATION FORM

		≥ <				
		, 0		9 %		
Name:			Date:			
Address:						
City:			Province: Postal Code:			
Phone:						
I am a relative of a person diagnosed with scleroderma*			would like to subscribe to the Scleroderma Manitoba THE BULLETIN want a tax receipt			
Donation Amount: □ \$200 □ \$100 □ \$50	\$25		Other: \$			
Cheque (Payable to Scleroderma Manitoba)						
IF YOUR DONATION IS IN MEMORY OR IN HONOUR OF A SPECIAL PERSON, PLEASE COMPLETE THE SECTION BELOW.						
☐ In memory of:						
☐ In honour of:						
☐ I would like more information on how to make a testamentary bequest to Scleroderma Manitoba						