



Healthcare Management Binder

Patient's Journal

2019 EDITION

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ACTELION PHARMACEUTICALS CANADA INC.



PERSONAL INFORMATION

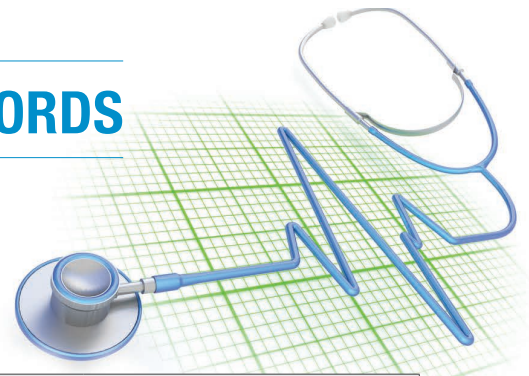
| | | | | |
|----------------------------|--------------------|--------------------|----------------------------------|---------------------|
| NAME: | | | GENDER: | |
| | | | Male | Female |
| ADDRESS: | | | HEALTH INSURANCE # : | |
| PROVINCE: | | | DATE OF BIRTH: | PLACE OF BIRTH: |
| | | | YR-MM-DAY | |
| 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 N° 2 : | | | | |
| EMERGENCY CONTACT NAME: | | | DRUG ALLERGIES : | |
| | | | | |
| TELEPHONE : | | RELATIONSHIP : | | |
| | | | | |
| EMERGENCY CONTACT ADDRESS: | | | FOOD OR ENVIRONMENTAL ALLERGIES: | |
| | | | | |
| TELEPHONE N° 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: | | | |

CARDIOPULMONARY RECORDS



| ECHOCARDIOGRAM | | | |
|----------------|----------|----------|-----------------|
| DATE | LOCATION | FINDINGS | RECORD OBTAINED |
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| PULMONARY FUNCTION TESTS (PFT) | | |
|--------------------------------|----------|----------|
| DATE | LOCATION | FINDINGS |
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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: | | | |

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 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

Phone: 204-510-2855

sclerodermamanitoba.com

info@sclerodermamanitoba.com

OUR MISSION

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

SUPPORT



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.



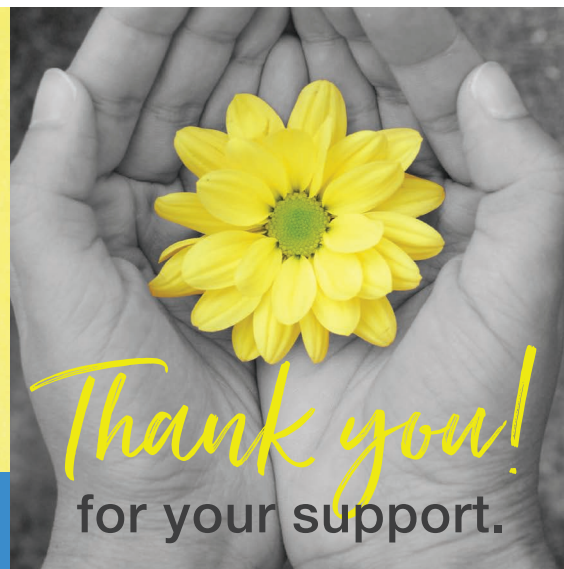
Scleroderma
M A N I T O B A

SCLERODERMA MANITOBA

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Email: info@sclerodermamanitoba.com

sclerodermamanitoba.com

Charitable Registration Number 861033819RR0001



DONATION FORM

| | | | |
|--|--|--|--------------|
| Name: | | Date: | |
| Address: | | | |
| City: | | Province: | Postal Code: |
| Phone: | | Email: | |
| <input type="checkbox"/> I have been diagnosed with scleroderma* <input type="checkbox"/> I am a relative of a person diagnosed with scleroderma* <small>*information will be kept strictly confidential</small> | | <input type="checkbox"/> I would like to subscribe to the Scleroderma Manitoba THE BULLETIN <input type="checkbox"/> I would like a tax receipt | |
| Donation Amount: <input type="checkbox"/> \$200 <input type="checkbox"/> \$100 <input type="checkbox"/> \$50 <input type="checkbox"/> \$25 Other: \$ | | | |
| <input type="checkbox"/> Cheque (Payable to Scleroderma Manitoba) | | | |
| IF YOUR DONATION IS IN MEMORY OR IN HONOUR OF A SPECIAL PERSON, PLEASE COMPLETE THE SECTION BELOW. | | | |
| <input type="checkbox"/> In memory of: | | | |
| <input type="checkbox"/> In honour of: | | | |
| <input type="checkbox"/> I would like more information on how to make a testamentary bequest to Scleroderma Manitoba | | | |