georgia memory net

Patient and Care Partner

"GRAB & GO" EMERGENCY DOCUMENTATION

This patient has been diagnosed with dementia. This might cause them to exhibit symptoms like change in gait, loss of balance, changes in personality and cognition, weakened eye movements, delayed response to questions, slurred speech, difficulty swallowing, extreme changes in blood pressure when altering positions, and stiffness or clumsiness in upper or lower extremities. **Always include a copy of patient's advanced medical directive and medical insurance ID cards.**

PATIENT INFORMATION

Name ____

Address ____

City ____________________ State ____________________ Zip ____________

Date of Birth ____________________ Social Security Number ________-______-________

Type of Dementia ____

Primary Care Physician ____________________ PCP Phone ____________________

Neurologist/Specialist Name ____________________ Phone ____________________

HEALTHCARE PROXY CONTACT INFORMATION

Name ____________________ Relationship to Patient ____________________

Contact Number ____________________ Alternate Number ____________________

Alternate Emergency Contact

Name ____________________ Relationship to Patient ____________________

Contact Number ____________________ Alternate Number ____________________

Does patient have an Advanced Healthcare Directive? YES / NO (circle one) If YES, please attach copy.

Power of Attorney Contact Information

Name ____________________ Relationship to Patient ____________________

Contact Number ____________________ Alternate Number ____________________

PATIENT HISTORY

CURRENT SYMPTOMS	MILD	MODERATE	SEVERE	COMMENTS
Thinking or memory problems				
Impulsivity				
Visual problems/light sensitivity				
Coughing/choking on solids				
Coughing/choking on liquids				
Speech problems				
Walking or balance problems				
Hand coordination				

PATIENT HISTORY, CONTINUED

Prone to falls? YES / NO (circle one) Backwards __ Forwards __

Current Medication List (dosage, frequency, what times of day) ______________________________

____

Is patient part of an experimental drug trial? YES / NO (circle one) If YES, which drug and why? ______________

Known Drug Allergies or Counterindications: ______________________________

Recent Hospitalizations (past two years, please include date and cause): ______________________________

Does the patient have any medical implants (like a pacemaker) or use any medical devices (like a nebulizer)? If so, what devices and why? ______________________________

CARE PARTNER PERSONAL INFORMATION

Just in case you have a medical emergency while caring for your person, please complete this section.

Care Partner Name ______________________________

Address ______________________________

City ______________________ State ______________ Zip ______________

Date of Birth ______________________ Social Security Number __________-______-__________

Primary Care Physician ______________________ PCP Phone ______________

HEALTHCARE PROXY CONTACT INFORMATION

Name ______________________ Relationship to Care Partner ______________

Contact Number ______________________ Alternate Number ______________

Alternate Emergency Contact

Name ______________________ Relationship to Care Partner ______________

Contact Number ______________________ Alternate Number ______________

Does patient have an Advanced Healthcare Directive? YES / NO (circle one) If YES, please attach copy.

Power of Attorney Contact Information

Name ______________________ Relationship to Patient ______________

Contact Number ______________________ Alternate Number ______________

CARE PARTNER HISTORY

Current Medication List (dosage, frequency, what times of day) ______________________________

____

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Additional Medical Information ______________________________

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