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) _____

_____

_____

Additional Medical Information _____

_____

_____