

My Personal Health Record

*Remember to take this record with you to all of your
medical appointments and hospitalizations.*

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the perfect balance between

health & care.

The Personal Health Record of:

_____ DOB: ____ / ____ / ____

Personal Information:

Address: _____

Home Phone: _____

Alternate Phone: _____

In Case of an Emergency Call:

Name: _____

Home Phone: _____

Alternate Phone: _____

Relationship: _____

Doctors I See:

Primary Physician: _____ Ph: _____

Other Doctors: _____ Ph: _____

Other Doctors: _____ Ph: _____

Community Services:

Home Care Provider(s)/Other Community Services (home health, meals, in-home care, community care manager):

Healthcare Wishes

- I do not have an advance directive.
- I have an advance directive.

The person I have named as my healthcare agent is:

Name: _____

Phone: _____

The person who has a copy of my advance directive is:

Name: _____

Phone: _____

Health Problems

- Arthritis
 - Abnormal Heart Rhythm
 - Cancer
 - Diabetes
 - Hardening of the Arteries
 - Heart Disease
 - Heart Failure
 - Other Diagnoses: _____
- High Blood Pressure
 - Hip Fracture/Replacement
 - Lung Disease
 - Medical/Surgical Back Conditions
 - Pacemaker Serial # _____
 - Pneumonia
 - Stroke
-

To better manage my health and medicines, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medicines or if I want to change how I take my medicines.
- Tell my doctors about ALL medicines I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medicine Record with any changes to my medicines.
- Know why I am taking each of my medicines.
- Know how much, when and for how long I am to take each medicine.
- Know possible medicine side effects to watch out for and what to do if I notice any.

Recent Test Results

Date	Weight	BP	HR	BS	Lab Result

BP = Blood Pressure

HR = Heart Rate

BS = Blood Sugar

Vaccines

Immunization	Date Received
Flu Shot (every year)	
Flu Shot (every year)	
Flu Shot (every year)	
Pneumonia	
Tetanus	

Hospitalization Information

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Hospital: _____

Reason: _____

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.

- I understand where I am going after I leave this facility and what will happen to me once I arrive.
 - Discharge to other facility
 - Discharge to a home health agency
 - Discharge home to care of self/family

- I have the name and phone number of a person I should contact if a problem arises during my transfer.

- I have given the name and contact information for any community services I receive to the hospital's discharge planner so they may be contacted.

- I understand what my medicines are, how to obtain them, and how to take them.

- I understand the potential side effects of my medicines and whom I should call if I experience them.

- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- I will have someone notify my community service providers when I am in the hospital.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This information is provided to the Atlanta Community through The Care Transition Demonstration Project and the Healthy Aging Coalition.

THE CARE TRANSITION PROJECT PARTNERS INCLUDE:

Visiting Nurse | Hospice Atlanta

A full service, non-profit home healthcare organization offering a full spectrum of home and hospice services to adult and pediatric patients.
www.vnhs.org | 770-454-0900

Atlanta Regional Commission, Area Agency on Aging

As the Area Agency on Aging (AAA), the Atlanta Regional Commission (ARC) plans and provides comprehensive services to address the needs of the region's older population.
www.agewiseconnection.com | 404-463-3333

Sixty Plus Older Adult Services, Piedmont Hospital

Providing services, education and support to older adults and their families.
www.piedmonthospital.org | 404-605-3867

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