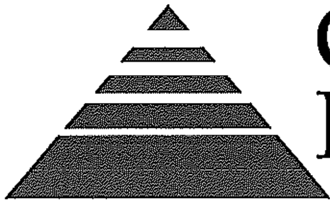


Crichton Rehabilitation Center

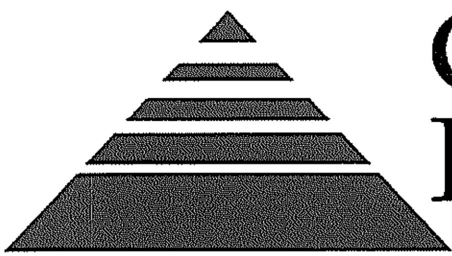
Member Conemaugh Health System

Thank you for choosing the Crichton Rehabilitation Center. We look forward to participating in your care. As part of your care, we have made this patient profile available for your use.

The patient profile is a snapshot of your medical history, which you can carry with you and update as your medical history changes. You may take this when you visit your physician, the hospital and any other medical provider. The intent is to help you take responsibility for your care.

If you would like assistance in understanding and initiating this profile please call Deneen Ault, RN, Quality Assurance Specialist at 534-7926.

Thank you.



Crichton Rehabilitation Center
Member Conemaugh Health System

My Healthcare Information

PATIENT PORTABLE MEDICAL PROFILE

NAME ______________________________

DATE UPDATED ______________________________

____

____

____

____

____

____

Provided by: Crichton Rehabilitation Center
320 Main St., 4th Floor
Johnstown, PA 15901

Mailing Address: Crichton Rehabilitation Center
1086 Franklin St.
Johnstown, PA 15905

Phone 814-534-7900 or Toll Free 888-488-9988
Fax 814-534-7930

My Healthcare Information

IDENTIFICATION

Name (Last) (First) (Middle) (Maiden Name)

Primary Address City State Zip Code

Home Phone Work Phone Cell Phone E-mail Address

Alternate Address City State Zip Code

Date of Birth	☐ Male ☐ Female	Height	Weight	Eye Color	Ethnicity/Race	Birthmarks/Scars	Blood/RH Type	Special Conditions

Marital Status Occupation Company Name

Languages Spoken - Primary and Secondary

EMERGENCY CONTACTS

Hospital Preference

In case of emergency, notify: primary contact

Name (Last) (First) (Relationship)

Home Address City State Zip Code

Home Phone Work Phone Cell Phone E-mail Address

In case of emergency, notify: secondary contact

Name (Last) (First) (Relationship)

Home Address City State Zip Code

Home Phone Work Phone Cell Phone E-mail Address

In case of emergency, notify: medical contact (indicate specialty)

Physician ______ Specialty ______ Phone ______

Physician ______ Specialty ______ Phone ______

Physician ______ Specialty ______ Phone ______

Healthcare Providers (ex: UCP, Hospice, Home Health) ______

INSURANCE PROVIDERS

Primary Insurance Provider

Company | Address | City | State | Zip Code

Contact | Phone | After Hours Phone Number

Identification/Group Number | Member (ID) Number

E-mail Address | Fax Number | Web Address (URL)

Primary Insured Person - Name | Social Security Number

Employer Name | Address | City | State | Zip Code

Employer Contact | Phone

Secondary Insurance Provider

Company | Address | City | State | Zip Code

Contact | Phone | After Hours Phone Number

Identification/Group Number | Member (ID) Number

E-mail Address | Fax Number | Web Address (URL)

Primary Insured Person - Name | Social Security Number

Employer Name | Address | City | State | Zip Code

Employer Contact | Phone

Tertiary/Long-Term Care Insurance Provider

Company	Address	City	State	Zip Code
Contact	Phone	After Hours Phone Number		
Identification/Group Number		Member (ID) Number		
E-mail Address	Fax Number	Web Address (URL)		
Primary Insured Person - NAME		Social Security Number		

EMPLOYER Name

	Address	City	State	Zip Code
Employer Contact	Phone			

DENTAL Insurance Carrier

Policyholder Name

Phone	Address	City	State	Zip Code

VISION Insurance Carrier

Policyholder Name

Phone	Address	City	State	Zip Code

AUTO Insurance Carrier

Policyholder Name

Phone	Address	City	State	Zip Code

LEGAL DOCUMENTS/MEDICAL DIRECTIVES

☐ Living Will

___ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.
___ I DO NOT with to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.
___ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my healthcare representative.

Document Location (physical location) ____________________

Location Name (example - Bank of America) ____________________

☐ Power of Attorney Document Location (physical location)	☐ Healthcare Representative Document Location (physical location)	☐ Guardianship Document Location (physical location)
Location Name	Location Name	Location Name
Address/P.O. Box	Address/P.O. Box	Address/P.O. Box
City State Zip Code	City State Zip Code	City State Zip Code
Legal Representative	Legal Representative	Legal Representative
Address/P.O. Box	Address/P.O. Box	Address/P.O. Box
City State Zip Code	City State Zip Code	City State Zip Code
Home Phone	Home Phone	Home Phone
Cell Phone	Cell Phone	Cell Phone
Home E-mail Address	Home E-mail Address	Home E-mail Address
Work Phone	Work Phone	Work Phone
Work E-mail Address	Work E-mail Address	Work E-mail Address
Fax	Fax	Fax

ORGAN DONATION: Organ Donor ☐ YES ☐ NO State Where Registered ____________________

MEDICATIONS

Include prescription, over-the-counter, vitamins, herbal supplements and oxygen.

Name of Drug	Dosage	Route (i.e.,oral, inhaler)	Frequency (i.e., every 4 hrs, twice a day, 2 weeks)	Date Medication Started	Reason started on medication	Physician

Allergy/Sensitivity (include medications, foods, environmental and other)	**Reaction** (i.e., rash, nausea, vomiting, difficulty breathing)	**Date LAST OCCURRED** (Allergy or Sensitivity)	**Treatment** (for Allergy or Sensitivity)

MEDICAL CONDITIONS/SURGICAL PROCEDURES

Major illnesses, previous hospitalizations, and surgical procedures. Include pregnancies and childbirth.

Date	Doctor	Nature of Health Problem	Age at Onset	Condition Status	Remarks (medications, special tests, x-rays, length of hospital stay, surgery, etc.)

RISK FACTORS

(not discussed within previous notes, such as high cholesterol, high triglycerides, etc.)

IMMUNIZATION STATUS

Have specifics written in with dates

- ☐ Influenza Vaccine — Dates Received: ____
- ☐ Pneumonia Vaccine — Dates Received: ____
- ☐ Tetanus Vaccine — Dates Received: ____
- ☐ Other Vaccines/Immunizations:

____ Date Received: ____

____ Date Received: ____

____ Date Received: ____

____ Date Received: ____

MEDICAL DEVICES

(such as pacemaker, insulin pump, breathing device, etc.)

DEVICE TYPE	Company providing device	Company Contact Number	Date of last service
Doctor	Hospital	Date	Reason

DEVICE TYPE	Company providing device	Company Contact Number	Date of last service
Doctor	Hospital	Date	Reason

DEVICE TYPE	Company providing device	Company Contact Number	Date of last service
Doctor	Hospital	Date	Reason

Device cards may be copied and attached to this page.

PHYSICAL LIMITATIONS/EQUIPMENT USED

Self Care - needs help with: (check those that apply) ☐ Eating ☐ Bathing/showering ☐ Grooming ☐ Dressing ☐ Toileting

Other (specify)

Equipment used | Company providing Equipment | Phone Number | Date of last Service

☐ Purchased ☐ Borrowed ☐ Leased

How long have you had this equipment?

Mobility: (check those that apply)

☐ Walking ☐ Walk with cane ☐ Walk with walker ☐ Wheelchair ☐ Able to climb steps

TRANSFERS requiring assistance: (check those that apply

☐ Car ☐ Bathtub/shower ☐ Toilet/commode

Equipment used | Company providing Equipment | Phone Number | Date of last Service

☐ Purchased ☐ Borrowed ☐ Leased

How long have you had this equipment?

Homemaking:

Need help with: (check all that apply) ☐ Transportation ☐ Meals/Cooking ☐ House Cleaning ☐ Shopping

Prosthetic/Orthotic equipment used (i.e., special shoes, artificial leg, arm, eye, etc.)

Type ________ Company ________ Phone # ________ Date Received ________

Components ________ History ________ Last Service ________

Type ________ Company ________ Phone # ________ Date Received ________

Components ________ History ________ Last Service ________

DIET TYPE (such as diabetic, low sodium, low cholesterol, sugar free etc.) ____________

FOOD CONSISTENCY ☐ Regular ☐ Soft Bite Size ☐ Ground ☐ Pureed ☐ Other (describe) ____________

LIQUID CONSISTENCY ☐ Thin/Regular ☐ Nectar ☐ Honey ☐ Pudding ☐ Other (describe) ____________

☐ DENTURES
  ☐ Upper ☐ Lower ☐ Partial/bridge

My Dentist is: ____________

Phone number: ____________

☐ Swallowing Difficulties

☐ Feeding tube

☐ Other ____________

VISION

☐ Glasses ☐ Blind in left eye

☐ Contact Lenses ☐ Blind in right eye

☐ Cataracts

☐ No problems with vision ☐ Other ____________

My Eye Doctor is: ____________

Phone number: ____________

HEARING

☐ Hearing loss in right ear ☐ Hearing aid for right ear

☐ Hearing loss in left ear ☐ Hearing aid for left ear

☐ Deaf in right ear ☐ No problem with hearing

☐ Deaf in left ear

My Hearing Doctor is: ____________

Phone number: ____________

SPEECH

☐ Clear ☐ Slurred ☐ Other ____________

☐ Unable to speak ☐ No problem with speech ____________

NOTES