

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.



## My Healthcare Information PATIENT PORTABLE MEDICAL PROFILE

			DATE UPDATED	NAME

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

Provided by:

Crichton Rehabilitation Center

Mailing Address: Crichton Rehabilitation Center

1086 Franklin St

Johnstown, PA 15905

320 Main St., 4th Floor Johnstown, PA 15901

My	Physician	Physician	Physician	Home Phone	Home Address	In case of emergency, notify: secondary contact Name (Last)	Home Phone	Home Address	In case of emergency, notify: primary contact Name (Last)	EMERGENCY CONTACTS	Languages Spoken - Primary and Secondary	Marital Status	Date of Birth	Alternate Address	Home Phone	Primary Address	Name (Last)	
City   State   City   State     Eye Color   Ethnicity/Race   Birthmarks/Scars   Bio   City   State     Eye Color   Ethnicity/Race   Birthmarks/Scars   Bio   Coccupation   Com   City   State     City   State     City   State     Cell Phone   Cell Phone     Specialty   State     Specialty   State     Specialty   Spec	We stable from the cells of more flower plants, the cells are sense.		y: medical contact (indicate :	Work Phone		y: secondary contact	Work Phone		y: primary contact	CONTACTS	nary and Secondary		Height		Work Phone		(First)	
Maiden Na late late late late late late late lat	Specialty	Specialty			City	(First)			(First)	Hospital Preference		Occupation	Eye Color	City		City	(Middle)	My Healthcare Info
	Phone	Phone	Phone	E-mail Address	State	(Relationship)	E-mail Address	State	(Relationship)			Company Name	Birthmarks/Scars Blood/RH Type	State	E-mail Address	State	(Maiden Name)	

## **INSURANCE PROVIDERS**

Contact Phone  Identification/Group Number Member (ID) Number	After Hours Phone Number		
	Withman		
		es femilies des des des des des mentre de children personales.	
E-mail Address Fax Number	Web Address (URL)	open gapaga and an analysis of the second se	
Primary Insured Person - Name	Social Security Number		THE REPORT OF THE PERSON NAMED AND ADDRESS OF THE PERSON NAMED ADDRESS OF THE PERSON NAMED AND
Employer Name Address	City	State	Zip Code
Employer Contact Phone			MAAAAA Pumiis
Secondary Insurance Provider  Company  Address	City	State	Zip Code
Contact	After Hours Phone Number	And the second s	
Identification/Group Number Member (ID) Number			with contract of the contract
E-mail Address Fax Number	Web Address (URL)		
Primary Insured Person - Name	Social Security Number		and the state of t
Employer Name Address	City	State	Zip Code
Employer Contact Phone			

Phone	Address	City	State	Zip Code
AUTO Insurance carrier		Policyholder Name		
Phone	Address	City	State	Zip Code
VISION Insurance Carrier		Policyholder Name		
Phone .	Address	City	State	Zip Code
DENTAL Insurance Carrier		Policyholder Name		
Employer Contact	Phone			and and any of the second seco
EMPLOYER Name	Address	City	State	Zip Code
Primary Insured Person - NAME		Social Security Number	)er	
E-mail Address	Fax Number	Web Address (URL)		
Identification/Group Number		Member (ID) Number	a a section (Alberta Periodic	and property of the second
Contact	Phone	After Hours Phone Number	umber	
Tertiany/Long-Term ©are Insurance Provider Company Address	<b>Provider</b> Address	City	State	Zip Code

LEGAL	LEGAL DOCUMENTS/MEDICAL DIREC	CTIVES
Living Will		
I wish to receive artificially supplied nutritic I DO NOT with to receive artificially supplied I nutritic I n	wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.  DO NOT with to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.  intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my healthcare representative.	is futile or excessively burdensome to me. ife is futile or excessively burdensome to me. ing the decision to my healthcare representative.
Document Location (physical location)		
Location Name (example - Bank of America)		
Power of Attorney	of Attorney ————————————————————————————————————	Guardianship
Document Location (physical location)	Document Location (physical location)	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	tered

### MEDICATIONS

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

						Name of Drug
	-			٠		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.

response and a state of the sta			-			Date
	- HIT		-			Doctor
	The state of the s					Nature of Health Problem
						Age at Onset Condition
		Administration of the state of				Condition Status
						Remarks (medications, special tests, x-rays, length of hospital stay, surgery, etc.)

### Have specifics written in with dates IMMUNIZATION STATUS (not discussed within previous notes, such as high cholesterol, high triglycerides, etc.) RISK FACTORS Other Vaccines/Immunizations: Influenza Vaccine Pneumonia Vaccine Tetanus Vaccine Dates Received: Dates Received: Dates Received: Date Received: Date Received: Date Received: Date Received:

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

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
NEW CONTROL OF TAPE	Company providing device Company providing device		and the state of the state of the service state of the service state of the service se
Doctor	Hospital	Date	Reason

Last Service	and the state of t	History		Components
		Phone #	Company	
Last Service		History	deret for expected for the decay products and more of the more than the	Components
Date Received		Phone#	Company	Туре
	c.)	artificial leg, arm, eye, et	d (i.e., special shoes,	Prosthetic/Orthotic equipment used (i.e., special shoes, artificial leg, arm, eye, etc.)
Shopping	House Cleaning	Meals/Cooking	Transportation	Homemaking: Need help with: (check all that apply)
How long have you had this equipment?	How !		Leased	Purchased Borrowed
Date of last Service	Phone Number	ose that apply et/commode Company providing Equipment	(check those that apply Toilet/commode Company prov	TRANSFERS requiring assistance: (check those that apply Car Bathtub/shower Toilet/commode Company prov
	Able to climb steps	ker Wheelchair	ne Walk with walker	Mobility: (check those that apply)  Walking Walk with cane
How long have you had this equipment?	How I		Leased	Purchased Borrowed
Date of last Service	Phone Number	Company providing Equipment	Compan	Equipment used
. Dressing Toileting	UIPMENT USED  nowering Grooming	PHYSICAL LIMITATIONS/EQUIPMENT USED that apply)	those that apply)	Self Care - needs help with: (check those that apply) Other (specify)
	ched to this page.	Device cards may be copied and attached to this page	Device car	
Reason	Date		Hospital	Doctor
Date of last service	Company Contact Number	Company providing device	Company pr	DEVICE TYPE
Reason	Date		Hospital	Doctor
Date of last service	Company Contact Number	Company providing device	Company pr	DEVICE TYPE
Reason	Date		Hospital	Doctor
Date of last service	Company Contact Number	Company providing device	Company pr	DEVICE TYPE

CIET TYPE (such as	(such as diabetic, low sodium, low cholesterol, sugar free etc.)	rol, sugar free etc.)	
	Soft Bite Size	Ground Pureed	Other (describe)
LIQUID CONSISTENCY Thin	Thin/Regular Nectar Honey	Pudding	Other (describe)
		My Dentist is:	
Swallowing Difficulties	ranambilage	Phone number:	
Feeding tube			
(			
Other			
VOISIV		and the second of the second s	
☐Glasses ☐Blind in left eye	eft eye	My Eye Doctor is:	
Contact Lenses Blind in right eye	ight eye	Dhone number	
Cataracts			
No problems with vision	Other		
<u>₽3</u>			
IMAZIZG			
Hearing loss in right ear	Hearing aid for right ear	My Hearing Doctor is:	
Hearing loss in left ear	Hearing aid for left ear	Dhone number	
Deaf in right ear	No problem with hearing		
Deaf in left ear			
SPINOL			
Clear	Slurred	Other	
Unable to speak	No problem with speech		

			•				NOTES