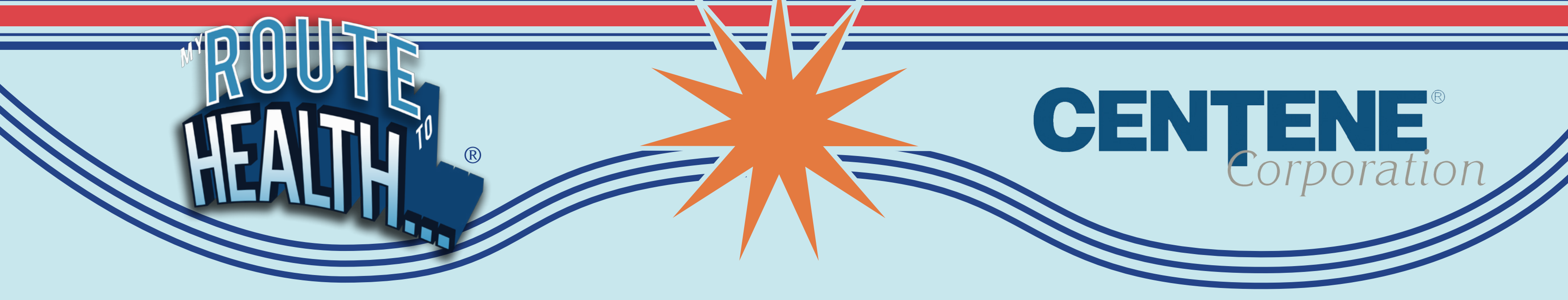

MY CARE PLANNER

GETTING ORGANIZED AROUND YOUR HEALTH!

Welcome to your Care Planner.

One of the most important things about your health journey is to have your information with you, as organized and up-to-date as you can. This helps you lower your stress and give your care team the most recent info about you and your health. This book will serve as a useful tool and a handy place to keep updates on your health.

Make sure to keep this with you and in a safe place at all times!

✓ CHECKLIST

Check off the forms in this book once completed.

- MY VALUES (p. 4)
- MY CHOICES (p. 5)
- MY GENERAL INFORMATION (p. 7)
- EMERGENCY CONTACT INFORMATION (p. 9)
- FAMILY INFORMATION (p. 11)
- MY MEDICAL INFORMATION (p. 12)
- MY MEDS, HERBAL SUPPLEMENTS AND VITAMINS (p. 16)
- MY DAILY MEDICINE SCHEDULE (p. 19)
- MY BLOOD PRESSURE LOG (p. 21)
- MY HYDRATION LOG (p. 22)
- MY MENTAL HEALTH HISTORY (p. 23)
- CURRENT ISSUES (p. 24)
- MY CONDITION (p. 26)
- MY DOCTORS (p. 27)
- MY CASE MANAGER (p. 28)
- MY RIDES (p. 29)
- MY APPOINTMENTS (p. 30)
- MY EXERCISE CHART (p. 32)
- WHEELCHAIR/WALKER SAFETY CHECK (p. 33)
- MY HOME CARE INFORMATION (p. 39)
- QUESTIONS FOR MY PHYSICAL THERAPIST (p. 42)
- MY DURABLE MEDICAL EQUIPMENT (p. 43)
- MY HEALTHY SHOPPING LIST (p. 46)
- MY DIETARY LIMITS AND CONDITIONS (p. 48)
- MY LONG-TERM CARE INFORMATION (p. 50)
- GOING BACK TO WORK QUESTIONS (p. 51)
- MY WORK PLAN (p. 52)
- OTHER CONTACTS (p. 53)

DISCLAIMER: This book provides general information about care planning and related issues. The information does not constitute medical advice and is not intended to be used for the diagnosis or treatment of a health problem or as a substitute for consulting a licensed health professional. Consult with a qualified physician or healthcare practitioner to discuss specific individual health needs and to professionally address personal medical concerns.

MY CARE PLANNER

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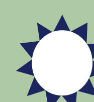

RESOURCES

YOUR HEALTHCARE CHOICES

ADVANCE DIRECTIVE

Everyone needs an advance directive, not just the sick or dying.
Anyone at any time can find themselves in a dire situation. You don't have to be sick or dying to think about your advance directive. You are the most important person who will ever be involved in your care. You have the right to make choices about your care. We want you to be active in all your healthcare choices.

It's a bad thought, but what if you became too sick to tell the doctor what you want your care to be? An **Advance Directive** is a way to make sure that your wishes are known.

You can decide **before** needing care or name someone to make those choices if you can't. All adults have a right to make Advance Directives for healthcare choices. This means planning for treatment, should there be a time when you can't speak for yourself.

Advance Directives may be made up of a:

- **Living Will**
- **Healthcare Power of Attorney**
- **"Do Not Resuscitate" Order**

Download your state's advance directive form here: uslwr.com/formslist.shtm

Talk to your doctor about this right.

Once filled out, your doctor can put the form in your file. Together, you can make choices that will put your mind at ease.

You can change your Advance Directive at any time, if you should ever need or want to. You should make sure others know you have an Advance Directive. Always carry an Advance Directive Notification Card in your wallet.

With an Advance Directive, you can be sure of being cared for as you wish at a time when you can't give the information.

YOUR QUALITY OF LIFE

You should be the one to decide what's of the greatest value to you and the quality of life you want to live. Making these choices while you're in charge of your life will make sure that your wishes are carried out.

Ask yourself these questions and talk about the answers with your family, closest friends and healthcare team:

- What scares you the most about being ill or hurt?
- How would you feel if you could no longer do the things you enjoy most?
- How would you feel if you could no longer think for yourself or make your own choices?
- How would you feel if you could no longer move by yourself and go places?
- How would you feel about being moved from your home?
- Would you want to be in a hospital or nursing home at the end of your life?

MY VALUES

Read the statements below and rate how much they mean to your life.	Very Important	Somewhat Important	Not Very Important
Caring for myself			
Getting out of bed each day			
Going out on my own			
Recognizing the people in my life			
Talking to and understanding others			
Deciding things for myself			
Staying in my home throughout my life			
Living without too much pain			
Living without the need for medical treatment or machines to keep me alive			
Paying my own expenses			
Leaving money to my family or a cause in which I believe			
Being faithful to my beliefs			
Living as long as I can			
Trying all medical treatment I can			
Not lingering before I die			

Physician's Orders for Life-Sustaining Treatment (POLST)

This program is an end-of-life plan based on talks with your doctors, healthcare team, loved ones and other patients. It makes sure that if you're seriously ill or frail, you can still choose your treatment. Your wishes will be documented and honored.

POLST.org

MY CHOICES

Picture yourself in each case below. What quality of life would you want during or after treatment? Decide which treatment you'd choose by writing YES or NO in each box.

IF I HAD...	I WOULD WANT... CPR	RESPIRATOR	TUBE FEEDING	KIDNEY MACHINE	PAIN MEDS	NO TREATMENT
A sudden complication ...and no other dire health problem						
...and other dire health problems, such as heart disease or a stroke						
A chronic illness ...and treatment took care of it						
...and treatment could no longer take care of it						
A deadly illness ...and treatment could still keep me active and in comfort						
...and treatment could no longer keep me active and in comfort						
An endless coma ...and no other health problems						
...and a lasting or deadly illness						

If you have a deadly illness or are in a coma, hospice care could be a choice. Hospice care keeps you in comfort until death.

Would you want hospice care? ______________________

YOUR WISHES

Writing down your wishes helps make them legal. Use the right forms for your state. A living will, a durable power of attorney for your healthcare or even both will help make your wishes legal and binding.

WHAT IS THAT?

Living will:

An advanced medical directive that has a written statement making clear a person's wishes about his or her medical treatment in cases in which he or she is no longer able to express these wishes.

U.S. Living Will Registry:
uslwr.com/formslist.shtm

Durable power of attorney:

A report that gives someone (the agent) the right to handle a person's healthcare matters.

US LEGAL Power of Attorney forms by state:
uslegalforms.com/powerofattorney

Do Not Resuscitate Order (DNR):

This is a legal order written in the hospital or on a legal form. It respects the wishes of a patient not to have CPR or cardiac life support if his or her heart or breathing stops.

American Medical ID:
DNR forms by state:
americanmedical-id.com/extras/dnr.php

Take the time to learn about these legal forms so you can make thoughtful and careful choices on your own behalf.

MY GENERAL INFORMATION

This section gives you a place for quick info. You will be able to fill out more facts about the topics below in the next sections.

This book collects and organizes data for:

First Middle Last

Nickname:

Prior Legal Names:

Date of Birth:

Month Day Year

Place of Birth:

City State Country

Main Home Address:

Street City State Zip Code

Cell Phone Number: (________) ______________________

Home Phone Number: (________) ______________________

Prior Address(es)

Street City State Zip Code

General Personal Information

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Military Service

Branch: ______

Date Enlisted: ______

Military Rank: ______

Military Bases: ______

______

______

Citation(s)/Award(s): ______

Date of Discharge: ______

Trade(s) ______

Company Name ______

Year of Hire ______ Year Left/Retired ______

My Family History

Mother's Name: ______

Mother's Maiden Name: ______

Date of Birth: ______

Place of Birth: ______

Father's Name: ______

Date of Birth: ______

Place of Birth: ______

EMERGENCY CONTACT INFORMATION

For:

____

First Name Middle Last

____

Month Day Year of Birth

First Emergency Contact

Name: ______________________________

Relationship: ______________________________

Cell Phone: (________) ______________________________

Home Phone: (________) ______________________________

Home Address: ______________________________

____

Work Address: ______________________________

____

Work Phone: (________) ______________________________

Email Address: ______________________________

Notes: ______________________________

____

____

____

____

____

Second Emergency Contact

Name: ______________________ Relationship: ______________

Cell Phone: (________) ______________________

Home Phone: (________) ______________________

Home Address: ______________________

Work Address: ______________________

Work Phone: (________) ______________________

Email Address: ______________________

Notes: ______________________

____

Other Emergency Information

Hospital of Choice: ______________________

Main Doctor: ______________________

Office Phone: ______________________

After Hours Phone Number/Answering Service: ______________________

Durable Power of Attorney Documentation Place: ______________________

Do Not Resuscitate Order (check one) ☐ YES ☐ NO

Location of Document: ______________________

Faith: ____________ Place of Worship: ______________________

Name of Religious Leader: ______________________

Phone: (________) ______________________

List of documents:

DOCUMENT	COMPLETED	LOCATION OF COPIES
Do Not Resuscitate Order		
Living Will		
Durable Power of Attorney		

My information

Use this section to gather information on all people in your family and their data.

Primary Contact: ______________________________

Spouse/Partner Date of Birth: ______________ ☐ Living ☐ Deceased

Spouse/Partner Place of Birth: ______________________________

Family Members

Name(s): Phone Numbers:

____

____

____

____

____

____

____

____

____

____

____

____

____

MY MEDICAL INFORMATION

Fill out this section with your latest information and update it as often as you can. Keep a file with medical records and facts of all health information. Once filled out, this will be a good source for a physician appointment or hospital admittance.

Insurance Information

Medicaid ID#	Office Address	Office Phone

Medicare ID#	Office Address	Office Phone

Independent Insurance Company	Office Address	Office Phone

Current Doctors

Name	Specialty	Phone	Nurse

Date	My Current Height	My Current Weight

Blood Type: ______________________________

Medical History

Date	Diagnosis	Operation Y/N	Operation Date

History of Falls

Date of Fall	Location	Injuries	Reported to Doctor?

Medical Information

Current Medical Conditions

Date	Diagnosis	Treatment

Blood Transfusions (check one): ☐ YES ☐ NO
Dates

____

____

Dominant Hand (check one): ☐ LEFT ☐ RIGHT

Birthmarks:

____

____

Food Allergies:

Food Type	Symptoms	Date Diagnosed

Prescription Allergies:

Drug Name	Symptoms	Date Diagnosed

Vaccinations:

TYPE	VACCINATION DATE	COMMON VACCINES	GUIDELINES
Influenza (flu)		Trivalent vaccines (protect against three flu strains); Quadrivalent vaccines (protect against four flu strains)	September or October is the best time to get a flu shot each year. It takes about two weeks for the flu shot to be most effective. The earlier in the flu season you get it, the better your odds of not catching the flu.
Shingles		Zostavax	This vaccine helps stimulate the immune system to fight disease caused by the virus, lessening the risk of getting shingles in people aged 50 and older. Studies show the shingles vaccine reduces the risk by about 50%.
Tetanus/DTaP		DTaP (diphtheria, tetanus and percussis) vaccine	Most children vaccinated with DTaP are protected throughout childhood. Booster shots in adulthood extend the protection.
Pneumococcal disease (pneumonia, meningitis, septicemia)		Pneumovax Prevnar 13	Can be given at any time of year; for adults 19-64 with certain medical conditions; adults 65 and up without a medical reason not to get it, as long as it's been 5 years since any previous dose.
Other			

Other Conditions and Equipment

Check Yes or No	YES	NO
Eyeglasses		
If yes, vision diagnosis (strength):		
Contacts		
If yes, vision diagnosis (strength):		
Hearing Aids		
If yes, LEFT, RIGHT or BOTH ears:		
Make:		
Model:		
Battery Type:		
Dentures		
Partial Dental Device		
Walker		
Cane		
Wheelchair		
Scooter		
Prosthetic Device		
If yes, specify:		
Insulin Kit		
Glucose Tablets		
Epinephrine Kit		
Glucometer		
ID/Medical Bracelet		
If yes, issued by:		
Alert Type:		
Nitroglycerine Patch		
Organ Donation		
Organ donation document location:		

MY MEDS, HERBAL SUPPLEMENTS AND VITAMINS

List the medications, herbal supplements and vitamins you take. Use the daily chart on page 19 to keep track of your doses.

PRESCRIPTION MEDICINES

BRAND NAME	GENERIC NAME	PRESCRIBED BY (DOCTOR)	CONDITION USED FOR

OVER THE COUNTER MEDICINES

BRAND NAME	GENERIC NAME	PRESCRIBED BY (DOCTOR)	CONDITION USED FOR

HERBAL SUPPLEMENTS

NAME	PRESCRIBED BY (DOCTOR)	USED FOR

VITAMINS

GENERIC NAME	PRESCRIBED BY (DOCTOR)	USED FOR

MY DAILY MEDICINE SCHEDULE

This form will help you keep track of your medicines and when you take them. Enter the name of the medicine in the first column and put a checkmark in the boxes for the time(s) you take that medicine each day. Take this chart with you to doctor appointments and keep it handy when you travel.

MEDICINE	BEFORE BREAKFAST Enter time:	WITH BREAKFAST Enter time:	BEFORE LUNCH Enter time:	WITH LUNCH Enter time:	BEFORE DINNER Enter time:	WITH DINNER Enter time:	BEFORE BEDTIME Enter time:	AT BEDTIME Enter time:	DURING NIGHT Enter time:

DRUG INTERACTIONS

Sometimes two or more drugs can conflict with each other in your system. This is called a drug interaction. It may cause side effects. A drug taken to help you sleep may mix badly with an allergy drug. The results can produce an adverse reaction, such as slowing down your reflexes, making driving a car dangerous. Elderly patients are often on many medications, so drug interactions are more likely.

Some medications cause reactions because they can aggravate a condition while treating another problem. Certain antacids contain aspirin, which is a known blood thinner. Even grapefruit can interact with some anti-depressants and cholesterol meds to produce reactions that can be hard to deal with.

Some conditions that may be aggravated by medications:

CONDITION	AGGRAVATING DRUG	POSSIBLE ADVERSE REACTION
Diabetes	Corticosteroids (Prednisone)	Drug-induced hyperglycemia
Osteoporosis	Corticosteroids (Prednisone)	Higher risk of fracture
Constipation	Anticholinergics/antihistamines/ narcotics	Slow gastrointestinal tract movement
Parkinson's	Antipsychotics	Aggravated movement disorder
Hypertension	Nonsteroidal anti-inflammatory drugs	Higher blood pressure due to fluid retention
Enlarged prostate	Anticholinergics/antihistamines	Urinary problems

MY BLOOD PRESSURE LOG

High blood pressure can be a silent killer. It's easy for this disease to go unnoticed and untreated. Be aware and check your blood pressure often. Many drug stores and groceries have machines that allow you to quickly check your blood pressure. Take your blood pressure at the same time each day, when your doctor says it's best.

Take up to three readings each time you test, about a minute apart, and record the results.

DATE/ TIME	1st READING		2nd READING		3rd READING		
	BLOOD PRESSURE	HEART RATE	BLOOD PRESSURE	HEART RATE	BLOOD PRESSURE	HEART RATE	NOTES
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		
	/		/		/		

CAUTION!

Call your doctor right away if your blood pressure is higher than 180/110.

MY HYDRATION

Water is the liquid of life, and making sure you're drinking lots of it every day is crucial. Staying hydrated is important for the whole body. The older we get, the less body water content we have. Between 20 and 80 years of age, we lose 15% of our body water and become more susceptible to dehydration.

Dehydration can lead to:

- Higher death rates among hospitalized older adults
- Emergency hospitalization
- Confusion
- Falling
- Constipation
- Impaired swallowing ability

Our sense of thirst also decreases as we age, raising the risk of dehydration. Our kidneys don't function as well the older we get. Drinking water can help them function properly.

Signs of slight dehydration:

Thirst, dry mouth, weak muscles, headache, tiredness.

Drink water regularly all day long, even if you're not thirsty.

Eight glasses a day is recommended:

- 1 when waking
- 1 at a morning break
- 1 at lunch
- 1 with a cup of coffee
- 1 in the afternoon
- 1 during late afternoon
- 1 with dinner
- 1 in the evening

Make your own Daily Hydration Log to keep track of your water intake each day.

DAILY HYDRATION LOG

DATE/DAY	TIME	AMOUNT

SOURCE:
h4hinitiative.com/hydration-and-health/different-needs-different-life-stages/hydration-and-elderly

MY MENTAL HEALTH HISTORY

Primary Care Provider: ____________________

Phone: (________) ____________________

Mental/Behavioral Care Provider: ____________________

Phone: (________) ____________________

Mental Health Conditions Now:

____

____

____

____

Past Mental Health Conditions:

____

____

____

____

Current Mental Health Medications:

Medicine	Dosage

Past Mental Health Medications:

Medicine	Dosage

Current Issues

Check each issue going on in your life right now.

- ☐ Sadness/Depression
- ☐ Death/Grief
- ☐ Irritability
- ☐ Overly Sensitive
- ☐ Sexual Abuse
- ☐ Disorganization
- ☐ Hallucinations
- ☐ Gambling Problem
- ☐ Compulsiveness
- ☐ Legal Problems
- ☐ Suicidal
- ☐ Anger/Rage
- ☐ Nervousness
- ☐ Panic Attacks
- ☐ Perfectionism
- ☐ Family Problems
- ☐ Memory Problems
- ☐ Delusions
- ☐ Alcohol Use
- ☐ Sleep Difficulties
- ☐ Money Problems
- ☐ Obsessive Worry
- ☐ Attention Problems
- ☐ Marital Problems
- ☐ Mood Swings
- ☐ Parent/Child Issues
- ☐ Domestic Abuse
- ☐ Language Problems
- ☐ Temper Outburst
- ☐ Drug Use
- ☐ Fatigue
- ☐ Work Issues
- ☐ Paranoia
- ☐ Distraction
- ☐ Restlessness
- ☐ Low Self Esteem
- ☐ Physical Abuse
- ☐ Social Skills
- ☐ Obsessive Thoughts
- ☐ Aggression
- ☐ Eating Disorder
- ☐ Chronic Pain
- ☐ Disability
- ☐ Forgetfulness

Family History of Mental Illness

Circle any of these conditions a parent may have experienced:

Schizophrenia	Anxiety	Suicide	Alzheimer's
Bipolar Disorder	Depression	Drug Dependence	ADD/ADHD
Alcoholism	Other: ______________________		

Alcohol Use

Now (amount/how often): ______________________

Past (at highest point): ______________________

Kinds used often: ______________________

____

____

Drug Use

Now (amount/how often): ______________________

Past (at highest point): ______________________

Kinds used often (include street drugs, sleeping medications, pain medications, anti-anxiety medications): ______________________

____

____

Tobacco Use

Now (amount/how often): ______________________

Past (at highest point): ______________________

Kinds used (cigarettes, cigars, pipe, chewing tobacco, nicotine, other):

____

____

Tried to quit? ☐ YES ☐ NO

Number of times: ____________

What have you used to try to quit? ______________________

MY CONDITION

Name of Condition: ____________________

Doctor Making Diagnosis: ____________________

CONDITION	DIAGNOSIS	LENGTH OF TIME SUFFERED

Questions for doctor or healthcare team about diagnosis:

How serious is my condition? ____________________

How long will my treatment last? ____________________

What will my treatment involve? ____________________

Write any other questions you may have below:

____

____

____

____

____

____

____

MY DOCTORS

Use this page to keep track of your doctors and their specialties.

Doctor's Name	Specialty (Primary Care, Specialist, Eye Doctor, etc.)	Location	Main Phone	Emergency Phone	Website or Email Address	Preferred Hospital

MY CASE MANAGER

A case manager is most often a trained nurse or social worker who works with providers in a clinic, hospital or doctor's office. They serve as go-betweens for patients and their doctors. She makes sure you understand advice from your healthcare team and anything that involves prescribed medicine. She can answer questions about your health issue, give advice and help you find the answers you may need.

Case Manager Name:

____

Company/Affiliation:

____

Phone:

(______)______________________________________

Email:

____

MY RIDES

NEED A LIFT?

Know how you're going to get there well before your appointment at the doctor's, the clinic, hospital or pharmacy. Buses, taxi cabs, friends and relatives can get you where you need to go, but you must plan it out and set up your rides there and back home ahead of time. In some cases, your case manager may be able to help you find ride options.

Bus Company:

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Taxi Service:

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Ride Service:

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Friend/Relative:

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Name: ______________________________ Phone Number: (______) __________

Add this info to the appointments log on the next page in the Type of Ride column.

MY APPOINTMENTS

Keep track of your medical appointments on this page. Refer to it often and keep it updated before and after your appointments.

Appointment	Location	Date/ Time	Type of Ride	Confirmed	Finished ✓

EXERCISING WITH MY CONDITION

Having a chronic condition shouldn't keep you from your exercise routine. Exercising can have many plusses for your health, especially if you have heart disease, asthma, diabetes or joint problems. Always talk to your doctors before starting an exercise plan and to figure out which exercises are safe for you.

Keep these exercise choices in mind and figure out which ones you can do:

MY EXERCISE CHART

Use this chart to keep on track with your exercise routine.

Date	Exercise	Repetitions/ Time Spent	Finished ✓

HOME SAFETY CHECK FOR WHEELCHAIRS AND WALKERS

MY WHEELCHAIR INFORMATION

Wheelchair Provider: ______________________

Model Name/Make: ______________________

Date Obtained: ______________________

Equipment Checked By: ______________________

MANUAL WHEELCHAIR:

Make of Chair: ______________________

Model of Chair: ______________________

Date Bought: ______________________

Chair Provider and #: ______________________

Chair Weight Limit (Pounds): ______________________

Use this checklist to make sure your equipment is working safely and at its best.

WHEELCHAIR SAFETY CHECKLIST

Keep your wheelchair maintained and repaired. This will keep you from having mishaps and make your wheelchair last longer.	
Always read the operating manual before using your wheelchair or any health equipment for the first time.	
Always lock the brakes before getting in and out of the wheelchair. Turn off the power on power wheelchairs to keep from having mishaps and save on battery life.	
Always lift up the footplates before getting in or out of your wheelchair.	
Don't take the anti-tip wheels or bars off. Doing so could make the wheelchair tip over backwards. Putting heavy loads on the back of the wheelchair could also make it tip.	
Make sure the wheel spokes are clear of objects.	
Never let kids play on or with your wheelchair. The battery case and footrest can break if they ride on it.	
Play it safe when riding on streets, especially at night. Use headlights, flashing taillights and flags.	
Never ride in the rain, as wheelchairs are not waterproof and could be a safety hazard.	
Be careful when riding up or down steep slopes so you don't tip.	
Program your power wheelchair so it doesn't go faster than you can control.	

MANUAL WHEELCHAIR QUICK CHECK

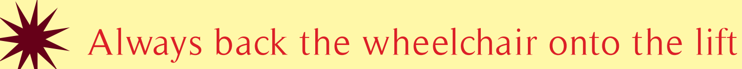
- ☐ Wheel locks engaging tires the right way
- ☐ Footrests there and in working order
- ☐ Upholstery in good shape
- ☐ Attaching hardware there and working
- ☐ Seatbelt/restraining straps in good shape and being used the right way
- ☐ Wheels in good shape
- ☐ Casters in good shape
- ☐ Frame in good shape
- ☐ Handgrips there
- ☐ Handgrips attach firmly to chair
- ☐ Wheelchair folds the right way
- ☐ Seat rail guides there
- ☐ Seat rail guides are working the right way
- ☐ Arms remove for transfer
- ☐ Leg rests lock in place when raised
- ☐ Handrails attach securely to wheels
- ☐ Handrails free from loose chrome or rough areas
- ☐ Chair attachments are there to keep it from tipping
- ☐ Tires inflated to right pressure (see stamp on tire or read manual)
- ☐ Pop off wheels lock securely in place on chair
- ☐ Worn tires replaced
- ☐ Wheelchair clean and in good shape

MOTORIZED CHAIR QUICK CHECK

Age and type of battery

- [ ] Call caps are there
- [ ] Battery connections are clean
- [ ] Battery charge indicator working (charge battery when gauge is at half or as manual says)

WHEELCHAIR LIFT SAFETY TIPS



- Always back the wheelchair onto the lift
- Get as close to the back of the lift as you can
- Never stand on the lift with wheelchair while the lift is in motion
- Lock the brakes on a manual wheelchair
- Turn off the power on a motorized wheelchair
- Press **unfold/deploy** to lower the lift to the ground
- Keep the wheelchair wheels off front lip or flap of lift
- Back the wheelchair into the van and position it facing forward – **to obey with the law, all wheelchairs <u>must face forward</u>**
- Move straps on the floor where needed
- Place back straps first above the axle on back of chair – **<u>don't crisscross the straps</u>**
- Place the front straps above the footrest
- Attach the safety restraint lap belt across the rider and the wheelchair – **to comply with the law, <u>safety restraint lap belt must be used</u>, even though the wheelchair has a lap belt**
- Do a final check of all straps and safety restraints

WALKER QUICK CHECK

Size of walker

- [ ] Non-skid tip on each leg of walker
- [ ] All latches work in folding walker
- [ ] All latches and buttons lock and work in the right way on height settings
- [ ] Handgrips are firmly attached
- [ ] Walker is clean and in good shape

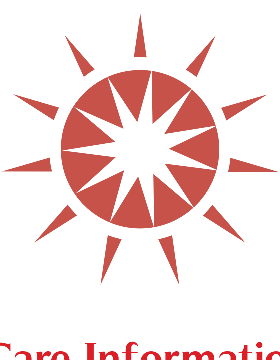
WALKER SAFETY TIPS

- Some walkers have wheels, some don't. Choose the style that's right for you.
- When going **up** a step or curb, start with your strong leg. When going **down** a step or curb, start with your weak leg, or the one you had surgery on.
- Keep your floors clean, dry and free of clutter.
- Hook a small basket or bag to your walker to hold items, keeping your hands free to hold on to the walker.
- Check the tips and wheels of your walker each day. Replace them when they become worn.
- When using your walker, don't wear shoes with heels or leather soles. Rubber-soled shoes and slippers or those with non-skid soles will help you to not fall.
- Always keep your toes inside your walker so you don't lose your balance.
- Don't use your walker to go up or down stairs or escalators.
- Check to make sure any loose rugs, rug edges that stick up or cords are secured to the ground. It's easy to get snagged and trip over them.

MY HOME CARE

Home healthcare from a visiting nurse or caregiver may be recommended by your doctor for a number of reasons:

- When you're returning from a hospital stay, nursing home or rehab site
- When you're dealing with a new diagnosis
- When you're taking new medications and need help
- When you're dealing with a chronic condition like cancer, heart disease, high blood pressure or diabetes
- When you're having behavioral issues
- When you need help with rehab gear or with home safety and getting place to place



Fill out your Home Care Information:

Home Care Provider:

____

____

Phone: (________)________________________

Caregiver Names:

____

Insurance Company:

____

____

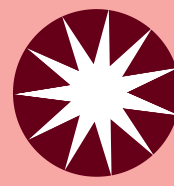
Case Manager Name:

____

Phone: (________)________________________

HOME HEALTHCARE QUESTIONS

ASK YOUR HOME HEALTHCARE AGENCY...	YES ✓	NO ✓
Have you been serving my area long?		
Are you approved by Medicare?		
Do you have brochures or a website that lists services and prices?		
Are you certified by a national accrediting group?		
Do you have a current license to practice (if needed in the state where you live)?		
Do you offer a “Patients’ Bill of Rights”?		
Do you write a care plan?		
Do supervisors oversee the home care staff?		
Is the home care staff available every day, at any hour, if needed?		
Do you supply a list of references for your caregivers?		
Do you ensure patient confidentiality?		
Do you offer financial aid or a sliding fee schedule?		



MY THERAPY AND REHAB

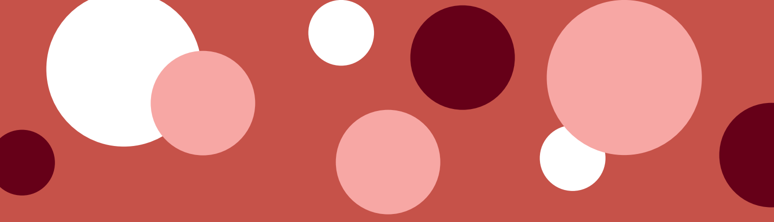
Dealing with pain, discomfort and lack of strength with a chronic condition is no picnic. Therapy and rehab can ease those things that hinder you and help you feel back to normal, especially after surgery or long bed rest.

Some types of therapy:

- Massage

- Stretching and movement

- Joint and muscle handling
- Core strengthening and muscle conditioning
- Manual therapy with hands or tools on soft tissue
- Yoga, pilates, swimming and exercise



DO THIS

Exercise for 30 minutes a day for three or four days each week

GET THAT

- **Strength in the muscles**
- **Endurance**
- **Joint stability**
- **Muscle and joint flexibility**
- **Less pain**

Finding the right mix of therapy, rehab and exercise is the key to pain management.

Less movement = more pain

More safe, therapeutic activity and exercise = less pain and better ability to function each day.

QUESTIONS TO ASK MY PHYSICAL THERAPIST

Q: Are you accredited? If so, by whom?
A: ______________________________

Q: Do you specialize in rehabilitation care?
A: ______________________________

Q: How soon should I start my therapy given my condition?
A: ______________________________

Q: Do you have medical staff ready at all times?
A: ______________________________

Q: How much therapy will I get?
A: ______________________________

Q: Will I be assigned a case worker?
A: ______________________________

Q: Will I be able to come back for outpatient therapy if I need it?
A: ______________________________

Q: Are you steady on your feet?
A: ______________________________

MY THERAPY AND REHAB

Name of Provider: ______________________________

Therapy/Rehab Specialty: ______________________________

Phone: (_________) ______________________________

Address: ______________________________

Website: ______________________________

Name of Provider: ______________________________

Therapy/Rehab Specialty: ______________________________

Phone: (_________) ______________________________

Address: ______________________________

Website: ______________________________

MY DURABLE MEDICAL EQUIPMENT

Check off your equipment:

- ○ Air-fluidized beds
- ○ Blood sugar monitors and diabetic testing strips
- ○ Canes
- ○ Commode chair and shower chair
- ○ Continuous Positive Airway Pressure (CPAP) machine
- ○ Crutches
- ○ Hospital bed
- ○ Home oxygen equipment and supplies
- ○ Infusion pump
- ○ Nebulizer
- ○ Patient lift
- ○ Suction pump
- ○ Traction equipment
- ○ Walker
- ○ Wheelchair

My Medical Equipment Supplier: ______________________________

Equipment: ______________________________

Date Acquired: ______________________________

Phone: (________) ______________________________

My Medical Equipment Supplier: ______________________________

Equipment: ______________________________

Date Acquired: ______________________________

Phone: (________) ______________________________

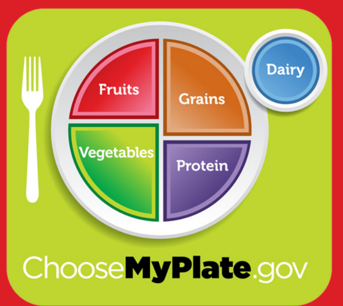
My Medical Equipment Supplier: ______________________________

Equipment: ______________________________

Date Acquired: ______________________________

Phone: (________) ______________________________

MY NUTRITION



Nutrition is a useful tool to keep from getting chronic diseases. It's also needed for keeping up with and treating chronic conditions. Healthy eating is a must, no matter your condition. Here are some healthy eating tips from ChooseMyPlate.gov:

TIP: Make half your grains whole

Foods made from wheat, rice, oats, cornmeal, barley or other cereal grains are thought of as grain products. These foods are bread, pasta, oatmeal, breakfast cereals, tortillas and grits. Eating whole grains as part of a healthy diet has shown a reduced risk of some chronic diseases.

TIP: Vary your veggies

Vegetables supply vitamins and minerals and most are low in calories. Make one fourth of your plate veggies. Veggies bright in color are vitamin and mineral-rich, as well as tasting great and being great for you.

TIP: Focus on fruit

Like vegetables, fruits lessen the chances of disease as they supply nutrients vital for health. Most fruits are naturally low in fat, sodium and calories and don't have cholesterol.

TIP: Get your calcium-rich foods

Milk, yogurt, cheese and soymilk make up the dairy group. They have calcium, vitamin D, potassium, protein and other nutrients needed for good health all through life.

TIP: Go lean with protein

We all need protein, and most people ages nine and up should eat five to seven ounces of protein foods each day. Protein foods come from both animals (meat, poultry, seafood and eggs) and plants (beans, peas, soy products, nuts and seeds).

SUGGESTED FOOD SHOPPING LIST

MILK & DAIRY

- Fat free or low fat milk
- Low fat yogurt
- Low fat cheese
- Cottage cheese
- Margarine

BREADS & GRAINS

- Whole wheat bread
- Whole wheat english muffins
- Corn tortillas
- Whole wheat tortillas
- Multigrain cereal
- Brown rice
- Enriched pasta

MEATS & BEANS

- White meat chicken (no skin)
- White meat turkey
- Lean beef
- Pinto beans
- Navy beans
- Black beans
- Fish
- Eggs

FRUITS

- Bananas
- Grapes
- Oranges
- Pears
- Peaches
- Strawberries
- Apples
- Canned fruit in light syrup
- Watermelon
- Cherries

VEGETABLES

- Carrots
- Broccoli
- Spinach
- Lettuce
- Tomatoes
- Green beans
- Canned or frozen vegetables (no salt)
- Collard greens
- Celery
- Peppers
- Onions
- Mushrooms
- Cucumbers

FATS, OILS & SAUCES

- Salsa
- Low or non-fat salad dressing
- Mustard
- Vegetable oil
- Vinegar

MY HEALTHY SHOPPING LIST

GRAINS	VEGGIES	FRUITS	DAIRY	PROTEIN

HEALTHY SHOPPING LIST, CONTINUED

GRAINS	VEGGIES	FRUITS	DAIRY	PROTEIN

MY DIETARY LIMITS AND CONDITIONS

- [ ] Check here if you have NO DIETARY RESTRICTIONS

Check any of these dietary restrictions you have:

- [ ] Lactose Intolerant
- [ ] Vegan... no animal products at all
- [ ] Religious Restrictions
- [ ] No/Low Sodium (Salt) Diet
- [ ] Food Allergy Restrictions
- [ ] Vegetarian
- [ ] No/Low Sugar Diet
- [ ] Low Fat Diet
- [ ] Gluten Free
- [ ] Other:

List any food allergies you have:

Health conditions that may limit food types and amounts:

Doctor Ordered Food Restrictions:

____
____
____
____
____
____

ACTION PLAN FOR FOOD REACTION:

Symptoms: ____
____
____
____
____

Actions to Take: ____
____
____
____
____

Emergency Contact: Name: ____________________ **Phone: (** _____ **)** ____________

Relationship: ____

MY LONG-TERM CARE

You may need long-term care to meet your personal needs. Not medical care, these services can help with the basic tasks of daily life, such as:

Bathing

Dressing

Using the toilet

Eating

Transferring (to or from bed or chair)

Caring for incontinence

Some long-term care services that help support everyday tasks are:

Housework

Taking care of money issues

Taking medication

Making and cleaning up after meals

Shopping for groceries or clothes

Using the phone or other devices

Caring for pets

Responding to emergency alerts such as fire alarms

Some insurance programs cover these services. If you think you could benefit from any of these services, talk to your case manager or provider.

Long-term Care Provider: ____________________

Phone: (________)____________________

Services: ____________________

Long-term Care Provider: ____________________

Phone: (________)____________________

Services: ____________________

Long-term Care Provider: ____________________

Phone: (________)____________________

Services: ____________________

GOING BACK TO WORK

No doubt your ability to work and keep your job after dealing with a diagnosis of a chronic illness is a great concern. To figure out if you're ready to go back to work after a serious illness or operation, ask yourself these questions:

Q: What does my company expect of me?

A: ______________________________

____

Q: Can I fulfill what they expect given my condition?

A: ______________________________

____

Q: What work tasks will I be limited in or need help doing?

A: ______________________________

____

Q: How might my symptoms affect my work skills?

A: ______________________________

____

Q: If I have to look for a new job, where will I look?

A: ______________________________

A: ______________________________

A: ______________________________

HELP YOUR WORKMATES HELP YOU

Chances are the people you work with are caring and kind. They'll want to know of your condition so they can help in an emergency. The main thing for them to know is to not panic. If you suffer from diabetes, for example, make sure your co-workers know how to act quickly in case of hypoglycemia. A little honesty, instruction and prep will go a long way in keeping you safe and getting you treatment should an emergency come up.

MY WORK PLAN

Employer:

____

Address:

____

Phone: (________)________________________________

Profession/Skill/Trade:

____

Supervisor:

____

Supervisor Phone: (________)____________________________

Supervisor Email:

____

Back to Work Target Date:______________________________

Expected Work Hours:__________ to __________

Days:

____

Hours per Week:__________

Emergency Kit Items:

____

____

Give your supervisors and nearby co-workers your **emergency contact info** upon going back to work.

OTHER CONTACTS

PLACE OF WORSHIP

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

FRIENDS

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

NEIGHBORS

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

OTHERS

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

Name: ______________________ Phone: ______________

GLOSSARY OF DAILY WELLNESS TERMS

ADULT DAY CARE

Community-based site that cares for adults in need who can no longer be left at home alone during the day. Some sites offer meals, activities and rides.

ADVANCE DIRECTIVE

A written document that says how you want medical choices to be made if you lose the ability to make them for yourself. This may be a Living Will, a Durable Power of Attorney for Health Care or both.

ALZHEIMER'S DISEASE

A form of dementia that affects how the brain works, causing loss of short-term memory, being able to reason and care for oneself and sometimes speak clearly. Though not curable now, many new meds can slow the progress of Alzheimer's for a lot of people.

ASSISTED LIVING FACILITY

A place that offers meals, housekeeping, rides, personal care and health services for people who need help with daily living.

ASSISTIVE EQUIPMENT

Products designed to help elders or people with disabilities lead more independent lives.

BLOOD PRESSURE

The pressure of the blood in the circulatory system, often measured for the force and rate of the heartbeat and the diameter and elasticity of the artery walls.

CASE MANAGER

A person (social worker or nurse) who helps in the planning, coordinating, monitoring and evaluating of medical services for a patient, focusing on quality of care, ongoing services and cost-effectiveness.

CERTIFIED NURSING ASSISTANT (CNA)

CNAs are trained and certified to help nurses by giving non-medical help to patients, such as help with eating, cleaning and dressing.

CHRONIC ILLNESS

A health condition that stays or has long-lasting effects, usually for more than three months.

CO-PAYMENT

A charge you pay for a certain medical service. For example, you may pay $10 for an office visit or $15 for a prescription and your health plan pays the rest of the cost.

DEDUCTIBLE

The amount you have to pay each year before your health insurance or Medicare starts to pay benefits.

DEMENTIA

A drop-off of mental abilities, such as vocabulary, abstract thinking, judgment, memory loss, most often brought on in one's later years.

DO NOT RESUSCITATE ORDER (DNR)

A legal order written to respect the wishes of a person not to have CPR or life support if his or her heart or breathing stops.

DURABLE MEDICAL EQUIPMENT

Medical equipment ordered by a doctor for home use, paid for by Medicare. These walkers, wheelchairs and hospital beds must be reusable.

DURABLE POWER OF ATTORNEY

A document that gives a certain person the right to handle healthcare matters related to someone else.

ELDER CARE

A wide range of services given at home, in the area and in home care places, such as assisted living sites and nursing homes.

ESTATE TAX

A tax put on a person's estate after he or she dies.

GERIATRICIAN

A doctor who specializes in the care of older people who are frail and have complex medical and social problems.

GLUCOMETER/GLUCOSE METER

A medical device for figuring how much glucose is in the blood.

GLUCOSE TABLETS

Tablets made of pure glucose that can be chewed to treat hypoglycemia in people with diabetes.

GLUTEN-FREE

A diet that has no foods with gluten, a protein found in wheat, barley, rye and triticale. A gluten-free diet is the only medically approved treatment for celiac disease.

HERBAL SUPPLEMENTS

Made from plants and meant to work along with widely used medical treatments. These are not looked at as drugs and are not ruled by the Food and Drug Administration (FDA).

HOSPICE CARE

Constant care given for a terminally ill person during the final stages of life. May be given at home, at a special site, a hospital or a nursing home. Physical care, counseling and comfort are part of this care, but it doesn't try to cure any illness.

INCONTINENCE
Not being able to control urination, bowel movements or both.

LACTOSE INTOLERANT
Not being able to fully digest the milk sugar (lactose) in dairy products.

MEDICAID
The U.S. program that pays for healthcare for people and families with low incomes or very high medical bills.

MEDICARE
The U.S. program that offers hospital and medical care to people age 65 or older, and to some younger people who are very ill or disabled.

NEBULIZER
A tool that makes a fine spray of liquid medicine that is inhaled to treat asthma and other breathing issues.

NITROGLYCERINE
A medicine that opens blood vessels for better blood flow, used to treat angina, a type of chest pain that occurs when not enough blood gets to the heart.

NURSING HOME
A state-licensed home that offers a room, meals, help with daily living, recreation and general nursing care to elderly or chronically ill people not able to take care of their day-to-day needs.

PHYSICAL THERAPIST
A rehabilitation pro that helps people become more mobile and regain strength and body movement after an illness or injury.

VEGAN
A person who doesn’t eat or use any animal products.

VEGETARIAN
A person who doesn’t eat meat and sometimes other animal products, most often for moral, religious or health reasons.

WILL
A written document that spells out to whom a person’s property, money and assets should go after death.

YOGA
A Hindu spiritual and body practice that uses breathing, meditating, stretching and body postures. Yoga is widely used for health and relaxation.

MY JOURNAL

A personal journal is a good way to put your feelings, beliefs and ideas down on paper. You don't have to share them with others, just yourself. Journaling can be a great form of therapy.

Try it on these pages. Then take it to a notebook or diary to keep a daily log of your written feelings.

DATE

DATE

MY NOTES

DATE

DATE

RESOURCES

Case Management Society of America
cmsa.org

U.S. Social Security Administration
SSA.gov

Medicare
Medicare.gov
1-800-MEDICARE
(1-800-633-4227)

Medicaid
Medicaid.gov
877-267-2323

U.S. Government Healthcare
Healthcare.gov

Disability.gov

Federal Transit Administration Transportation for Elderly Persons and Persons with Disabilities
fta.dot.gov/grants/13093_3556.html

American Heart Association
Heart.org

American Lung Association
Lung.org

American Diabetes Association
Diabetes.org

USDA ChooseMyPlate
ChooseMyPlate.gov

American Bar Association
Commission on Law and Aging
202-662-8690
abanet.org/aging/toolkit/home.html

National Hospice & Palliative Care Organization
800-658-8898
nhpco.org

U.S. Administration on Aging: Eldercare Locator
1-800-677-1116

Show your Doctor All Medications!

1. Collect all of your prescriptions in a bag
2. Take the bag with you to your doctor.
3. Show these to your doctor so he or she knows what you are taking. Mention any herbal and over-the-counter medicines you take as well.

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MY CARE PLANNER

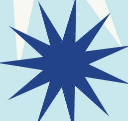
GETTING ORGANIZED AROUND YOUR HEALTH!

Day by day, you can see to the ins and outs, ups and downs, and steps both major and minor in caring for your own health.

Use this book to...

Keep track of your personal information and contacts

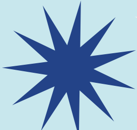
Learn how to take care of your condition


Log your medicines and care schedules

Write down questions for your healthcare team

Find help and resources

Get nutrition tips


And much more

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