ADD NAME

Add Mailing Address
Email, home phone, cell phone

INSURANCE	BlueCross BlueShield of Mass	Primary	Subscriber Name and # XXX-XX-XXXX BC/BS PPO Plan Code 200 Customer Service: 800-296-xxxx
		Secondary	Subscriber Name and # XXX-XX-XXXX BC/BS Blue Choice Plan 2, POS Code 200, Customer service: 800-222-xxxx

Legal Health POA *	Name	Relationship	C XXX-XXX-XXXX	W XXX-XXX-XXXX	H XXX-XXX-XXXX
	Name	Name	C XXX-XXX-XXXX	H XXX-XXX-XXXX	W XXX-XXX-XXXX

DOB 05-24-1973 **HEIGHT/WEIGHT:** 4' 3", 80 lbs **DNR SIGNED:** No **ORGAN DONOR:** No
SS# XXX-XX-XXXX **BLOOD TYPE:** A positive **ADVANCED DIRECTIVES:** Yes

- **High intelligence** (130 IQ), compliant patient, high tolerance to pain
- Incomplete Quad (has sensation), only movement left index finger 10 cm
- Need to explain EVERY procedure, when possible, ask for consent prior to doing
- **If unable to talk => one blink = yes / two blinks = no** - Read his lips - OR - letter/word board to direct his care.

ALLERGY: Sulfa, Adhesive Tape

HEALTH ISSUES		
Neuro Muscular	ICD-9 359 MD 335.1 SMA	Spinal Muscular Atrophy Type 2, dx age 9mos, 3/74 (Severe Anterior Horn Cell disease/Werdnig-Hoffman) Incomplete quad (has full sensation), no functional movement
Pulmonary	ICD-9 V44 Trach 518.81 Resp Failure 486 Pneumo Org NOS	Respiratory failure - trach and vent (9/01), Chronic RLL Atelectasis Recurrent pneumonia, Respiratory insufficiency, poor residual functions/reserved capacities, Elective Trach 3/82 for Ortho Surgery

MEDICATIONS

Rx DAILY
1. Alprazolam (xanax) 0.5 mg QID anxiety
2. Aspirin-Child 81 mg 1 x prevent clots
3. Temazepam 15 mg H S sleeping pill
4. DuoNeb 1 vial QID nebulizer
(Ipratropium, Bromide & Albunterol)

Rx MONTHLY
1. Thiamine 100 mg monthly vitamin
2. Cyanocobalamin 1000 mcg/ml monthly (B12)

Rx PRN
1. Darvocet-N pain
2. Zithromax SUS PFIZ 200/5ml 45ml antibiotic
3. Diphnoxylate/atropine 1-2 tablets diarrhea

HERBS / DROPS

1. Lymphatic	5	x2
2. Flu Balancing	10	x2
3. Respiratory	7	x2
4. Allertox –airborne	5	x2
5. " " Aleer-Total	3	x3
6. " " Allerdrain	10	x4
7. Immune	6	x2
8. Acute Rescue	5	x2
9. Urinary	8	x2
10. Digestive	3	x2
11. Mucous	5	x2
12. Cell	7	x2
13. Muscular	4	x2
14. Integumentary	8	x2
15. Er Cheng Tang	1 tsp	x2

VENT – Pulmonetic LTV 900

Breaths 05
Tidal Volume 310
Inspiration 1.1
Pressure Support 13
Sensitivity 02
High 40
Low 02

TRACH: Shiley 6 cuffed (deflated)

SPEAKING VALVE: Passy-Muir PMV007

OXYGEN 1.5 liters

MEDICAL HISTORY		
GI		Decreased esophageal motility, s/p feeding
	SURGERY	
	ICD-9 V44.1	Gastrostomy tube, Foley 24Fr Age 10, 7/83, Cincinnati Children's Hospital: Dr. Martin
Ortho	ICD-9 737.4 ICD-9 754.89 ICD-9 754.81	Severe deformities: thoracic, pelvic obliquity, bilateral dislocated hips, flexion contractures, pectus excavatum
	SURGERY	
	ICD9- 81.0	Spinal fusion /Lueke Rod Age 9, 3/82, Cincinnati Children's Hospital: Dr. Alvin Crawford
Urological	ICD-9 752.51 753.3, V13.02	Undescended L testicle (since birth), Kidney Stones (3/79, 6/90); IVP (6/90) Intermittent cath: Age 28, 10/01, cath: 10 Fr
	SURGERY	
	ICD9- 752.51	Cystoscopy/left ureteral stent, Age 28, 10/01
Other	***SURGERY***	IV: Porta Cath (10/24/01) RIS right clavicle (PC 0603880 - lot 36HI124)

IMMUNIZATIONS						
Tetanus '85	TB '78, '87	Pneumococcal vaccine '79, '01	Flu '02	Mumps '74	Measles '74	DPT '73, '79

PHYSICIANS			
INTENSIVIST	Melvin XXXX, MD	XXX-XXX-XXXX	XXXXXXX, Ocala, FL 34482
ACUPUNCTURE	Barbara XXXXX RN, AP	XXX-XXX-XXXX	XXXXXXX, Ocala, FL 34482
PULMONOLOGIST	Robert xxx XXXXX MD	XXX-XXX-XXXX	XXXXXXX, Gainesville, FL 32608

OTHER			
BC/BS Case Manager	Debra XXXXXXX	800-392-xxxx	XXXXXXX, Ocala, FL 34482
Rx –Pharmacy	Bitting's	352-732-xxxx	XXXXXXX, Ocala, FL 34482
Dental	Yvette Gaya , DMD	352-xxx-xxxx	XXXXXXX, Ocala, FL 34482

NAME Address, Home Phone, Cell Phone, Email			
DOB	SS#	**Allergy**	**DNR SIGNED: N/ Y – ADD DATE**
Learns best by:			
Supports Needed:			
Legal Decision Maker: __Self		**Guardianship: __ Limited __ Full**	
NAME: ADDRESS:		PHONE:	
Legal Health Surrogate:			
NAME:		PHONE:	

PRIMARY DIAGNOSIS/ICD-9 CODES	**AGE: XX** **HEIGHT X'X"** **(XX inches)** **WEIGHT XX lbs**
1. 2. 3. 4. 5.	

MEDICAL	
DOCTORS	**HOSPITAL**
MEDICINES Rx DAILY Rx MONTHLY Rx PRN	**IMMUNIZATIONS**
ADD NAME OF INSURANCE COMPANY *Primary Subscriber:* ADD NAME ADD Plan Code # ADD Subscriber # Customer service: ADD PHONE #	ADD NAME OF INSURANCE COMPANY *Subscriber:* ADD NAME ADD Plan Code # ADD Subscriber # Customer service: ADD PHONE #

Health Care/ Case Manager	ADD NAME	ADD PHONE #	ext. xx
Health Vendor	ADD COMPANY NAME/CONTACT	ADD PHONE #	ADD acc't. #
Home Nursing Agency	ADD COMPANY NAME/CONTACT	ADD PHONE #	ADD acc't. #
Pharmacy	ADD COMPANY NAME	ADD PHONE #	ADD RX #s
Dentist	ADD NAME	ADD PHONE #	