



URGENT CARE OR HOSPITAL VISIT

Take to Urgent Care or Hospital Visits

I have a developmental disability. I think it will help you care for me if you know a little bit about how my disability affects me when I am well. It means there are things I can do, things I need help with, and things I cannot do. Please place this information in my chart so that it may help everyone who will care for me while I am here. Thank you.

Date _____ My name is _____ I like to be called _____ Room # _____

Person with me is _____ Contact: _____

Person making my medical decisions today is _____ Contact: _____

My regular Dr. is _____ Contact: _____

I have these allergies: _____ My triggers/sensitivities are: _____

I am here because:

<input type="checkbox"/> I hurt myself	How?	When?
<input type="checkbox"/> I am in pain	<input type="checkbox"/> Sharp <input type="checkbox"/> Ache	Where?
<input type="checkbox"/> I am sick	How long?	
<input type="checkbox"/> I am short of breath	<input type="checkbox"/> I have chest pains	<input type="checkbox"/> I passed out
<input type="checkbox"/> I keep throwing up	<input type="checkbox"/> I have diarrhea/cramps	
<input type="checkbox"/> I have a bad <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> earache		
<input type="checkbox"/> I had a seizure It lasted _____ minutes Other _____		
I usually treat the issue by _____		

I am currently being treated for:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Bladder infection	<input type="checkbox"/> Lung/breathing problem	<input type="checkbox"/> Stomach	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Thyroid	Other _____	

What you should know about me and how my disability affects me:



Physically:

<input type="checkbox"/> I can push the call button	<input type="checkbox"/> I cannot push the call button		
<input type="checkbox"/> I walk unaided	<input type="checkbox"/> I walk slowly	<input type="checkbox"/> I use a walker	<input type="checkbox"/> I use a wheelchair
Other _____			

With help I can:

<input type="checkbox"/> Do my personal cares	<input type="checkbox"/> Get in and out of bed	<input type="checkbox"/> Go to the bathroom
<input type="checkbox"/> Feed myself	<input type="checkbox"/> Take medication	

I will need to be:

<input type="checkbox"/> Lifted in and out of bed	<input type="checkbox"/> Fed	<input type="checkbox"/> Bathed	<input type="checkbox"/> Toileted
<input type="checkbox"/> Given medication			
Other _____			

Communication:

<input type="checkbox"/> I can speak for myself, please try to listen	<input type="checkbox"/> I cannot speak for myself			
<input type="checkbox"/> I am deaf/hard of hearing	<input type="checkbox"/> I have an interpreter			
I can communicate through:				
<input type="checkbox"/> Computer	<input type="checkbox"/> Gestures/facial expressions	<input type="checkbox"/> Sign language	<input type="checkbox"/> Pictures	<input type="checkbox"/> I can write things down

Understanding:

<input type="checkbox"/> I can understand what you say to me
<input type="checkbox"/> I like simple terms and step by step directions
<input type="checkbox"/> I may not understand what you say to me

Special concerns and/or fears:

When I am anxious or frustrated it helps me feel better if I have: _____

<input type="checkbox"/> It is hard for me to sit still
<input type="checkbox"/> I am fearful of: <input type="checkbox"/> Medical exams <input type="checkbox"/> Being touched <input type="checkbox"/> Shots Other _____
Please tell me before you do any of these things (list):

People in my life:

Relationship	Name	Phone number
Family Member:		
Guardian:		
Attendant:		
Support Person:		
Home Health:		

Medical decisions, Advanced Directive, and/or Power of Attorney information:
