CareZoom™ *Post in Easily Viewable Areas*

HOT LIST for EMERGENCY SERVICES and CAREGIVERS

Patient Name: _____ Update Date: _____

Current Location: _____ Phone: _____

Family Caregiver Name: _____ Cell Phone: _____

Secondary Caregiver Name: _____ Cell Phone: _____

Primary Doctor, Name, Location, Phone: _____

Pharmacy Name, Location, Phone: _____

Medication List: *use reverse to add more details – When using a pill box make sure to keep the original RX bottle. Original container has name, pharmacy info, RX # for confirmation*

Allergies: _____

Medical Devices: *e.g. implant, hearing aid, eyeglasses, denture, pacemaker, prosthetic, other list*

Mental Capacity and other alerts: *e.g. dementia, schizophrenia, autism, other list*

Prior Trauma: *e.g. diabetic, stroke, heart attack, other list*

List other important necessities or awareness: *e.g. native language, religion, organ donor, pets, alarm systems, restraining orders, other list*

_____

Keep information updated. Ver 2.0

In the event of an EMERGENCY CALL 911 immediately

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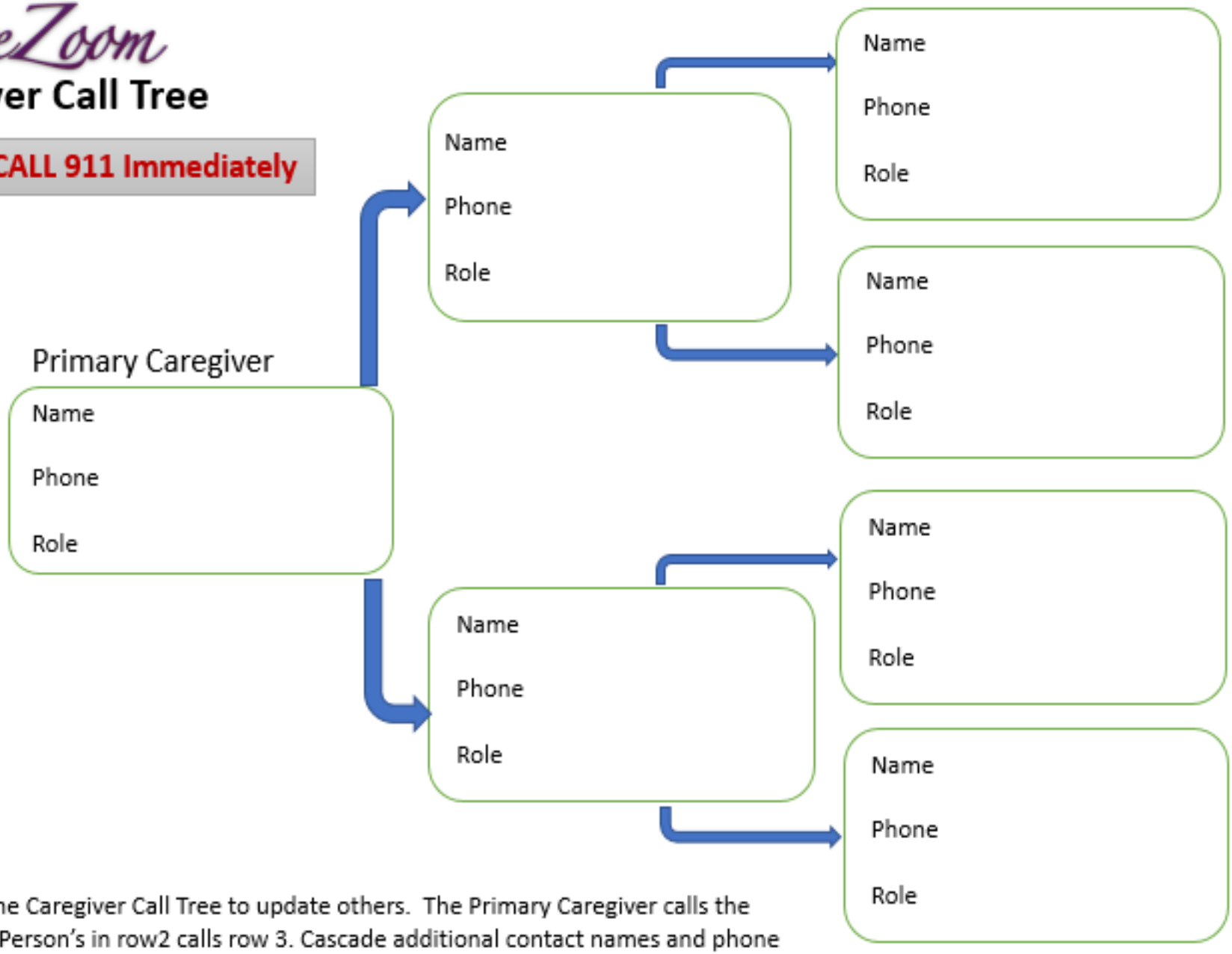
Caregiver Call Tree

Emergency CALL 911 Immediately



Instructions: Use the Caregiver Call Tree to update others. The Primary Caregiver calls the person's in row 2. Person's in row2 calls row 3. Cascade additional contact names and phone numbers until you have a complete Caregiver Phone Tree

Section 3 – Schedule for Helping

CareZoom

When	WHO WILL DO WHAT TO DO	WHO WILL DO WHAT TO DO	WHO WILL DO WHAT TO DO	WHO WILL DO WHAT TO DO
SUNDAY				
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				

Notes

Write in the activities assigned to family and friends... In an emergency call 911 immediately.

Section 5

Be an Active Member of Your Health Care Team DEPARTMENT OF HEALTH AND HUMAN SERVICES

My Medicine Record

Name *(Last, First, Middle Initial):* Birth Date *(mm/dd/yyyy):*

	What I'm Using Rx - Brand & generic name; OTC - Name & active ingredients	**What It Looks Like** Color, shape, size, markings, etc.	**How Much**	**How to Use / When to Use**	**Start / Stop Dates**	**Why I'm Using / Notes**	**Who Told Me to Use / How to Contact**
Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements							
Ex:	XXXX/xxxx EXAMPLE	20 mg pill; small, white, round	40 mg; use two 20 mg pills	Take orally, 2 times a day, at 8:00 am & 8:00 pm	1-15-11	Lowers blood pressure; check blood pressure once a week; blood test on 4-15-11	Dr. X (800) 555-121 EXAMPLE
1							
2							
3							
4							
5							
6							
7							
8							

(888) INFO-FDA These are my medicines as of _____

(Enter date as mm/dd/yyyy):

www.fda.gov/Drugs/ResourcesForYou/ucm079489.htmwww.fda.gov/usemedicinesafely

PSC Publishing Services (301) 443-6740 EF

Section 5

Be an Active Member of Your Health Care Team DEPARTMENT OF HEALTH AND HUMAN SERVICES

My Medicine Record

Food and Drug Administration

My Personal Contacts

My Name *(Last, First, Middle Initial)*	Birth Date *(mm/dd/yyyy)*
Contact Information	

Emergency Contact

Name	Relationship
Contact Information	

Primary Care Physician

Name

Contact Information

Pharmacy / Drugstore

Name

Contact Information

Allergic Reaction or Other Problem I've Had With…

any medicine, dietary supplement, food, skin cleaner, medical tape

Describe in space below.

My Medical Conditions and Operations

Describe in space below.

Questions I Should Ask About Medicines or Dietary Supplements

Fill in the record for any new medicine, prescription (Rx) or over-the-counter (OTC), or dietary supplement, or ask my doctor or pharmacist to help me fill it in. Make sure I can read what is written on the record.

When I review the record, or a change is made, ask:

- Can I use a generic form?
- When should I start to feel differently? When should I report back to the doctor?
- Will this take the place of anything else I am using?
- Are there any special directions for using this?

Should I avoid any other medicines, dietary supplements, or treatments while using this?

Should I avoid any drinks, foods, other substances, or activities while using this?

What are the possible side effects from this? Is there anything I should watch for? What do I do if I get a side effect?

Will I need any tests (blood tests, x-rays, other) to make sure it is working as it should? When? How will I get the results?

What should I do if I miss a dose? What do I do if I use too much?

Where and how can I get more written information about this?

Section 6

Daily Necessities – Use reverse if necessary	***Notes:***
Bathing, showering, bathroom essentials	
Blanket, pillows, comfort items	
Books, magazines, bible, religious books	
Cell phone/charged or landline	
Cleaning and installing dentures	
Cross word puzzle and other games	
Dressing	
FRESH Air time	
Glasses, hearing aids, other aids	
Hair care, personal hygiene	
Meals and snacks	
Nail trimming (hand and feet)	
Pet care – attending to walking, feeding pet(s)	
Spiritual care and comfort	
TV remote control – schedule of favorite shows	

Verify Emergency Hot List - accurate contacts	

Section 8 Location Medical Items

Medical Item	Location of item, brand/type, size and instructions	Reorder Re-stocking

Legal Form Name	Last Update Date	Location of Form

Section 9 Important Note: Each document likely requires signatures and authorities which vary by state. The intent of this list is to provide whereabouts of the location of these forms for proper use.