HEALTHY COMMUNITIES AND
WORLD CLASS HEALTHCARE
CARING | PASSIONATE | TRUSTWORTHY

Record of Care

This booklet outlines the main things about my life that are important for my ongoing health

Date:

BENDIGO HEALTH

My full name is: _____

I prefer to be called: _____

My address

_____

_____

I am: □ **Male** □ **Female**

My date of birth is:

Day_____/Month_____/Year_____

I am: □ **Married** □ **Widowed**

□ **Divorced** □ **Never married**

□ **Other: please specify: _____**

My Next of Kin (NOK) is:

1. **Name: _____**

   Contact numbers: Home: _____

   Mobile: _____

If my NOK can't be contacted, please contact:

2. **Name: _____**

   Contact numbers: Home: _____

   Mobile: _____

Or contact:

3. **Name:** _____

Contact numbers: **Home:** _____

Mobile: _____

I have special communication needs that mean I need you to (eg; get an interpreter; write things down; show me pictures etc)

_____

_____

_____

The Doctor I usually go to is:

Name:_____

Phone number: _____

The Specialist I go to is:

Name:_____

Phone number: _____

The chemist that I usually go to is:

Name: _____

My case manager, the one who co-ordinates my care and services is:
Name: _____

Phone number: _____

My Enduring Medical Power of Attorney is:

Name: _____

Phone number: _____

My Enduring Financial Power of Attorney is:

Name: _____

Phone number: _____

My Enduring Guardian is:

Name: _____

Phone number: _____

My Administrator is:

Name: _____

Phone number: _____

I have written an Advance Care Plan and the following person knows where it is:

Name: _____

Phone number: _____

My Medicare card number is: _____

My Pension card number is: _____

My DVA card number is: _____

My Private Health Insurance number is: _____

I am an Ambulance member: □ **Yes** □ **No**

My Ambulance number is: _____

I am allergic to the following medication, food and/or products:

_____

_____

_____

_____

I have had vaccinations for:

□ **The flu; Date that I was vaccinated was:** _____

□ **Tetanus; Date that I was vaccinated was:** _____

□ **Other; Specify:** _____

Date that I was vaccinated was: _____

I was last admitted to hospital in: **Date:** _____

Hospital Name: _____

I was admitted to hospital for: (reason why)

_____

_____

_____

_____

I have the following medical conditions and/or disabilities:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medications

I take the following medications:

Name: _____ Strength:_____

I take it: □ Morning □ Lunchtime □ Afternoon □ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: ___________________ Strength:_________________

I take it: ☐ Morning ☐ Lunchtime ☐ Afternoon ☐ Night

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

I take the following vitamins, herbs and/or natural remedies:

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

Name: _____ **Strength:**_____

I take it: ☐ **Morning** ☐ **Lunchtime** ☐ **Afternoon** ☐ **Night**

I use the following aids and/or equipment to help me:

- ☐ **Glasses for reading** ☐ **Glasses for long distance**
- ☐ **Glasses for everything**
- ☐ **Hearing aid:** ☐ **left ear** ☐ **right ear** ☐ **both ears**
- ☐ **Dentures:** ☐ **upper** ☐ **lower** ☐ **both**
- ☐ **Walking stick** ☐ **walking frame**
- ☐ **Motorised scooter**
- ☐ **Shower chair**
- ☐ **Over-toilet seat**
- ☐ **Commode at night**

Other: (list)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I tend to fall: ☐ **rarely** ☐ **occasionally** ☐ **Often**

My last fall was:

(When): _____

(why/how): _____

_____

_____

_____

_____

Health Summary (this information is important for you to know about my overall health and well being):_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have cultural and/or religious beliefs that mean you need to know the following:

I have been assessed as eligible for:

☐ **Low level care** ☐ **High level care** ☐ **Respite care**

I receive the following help:

Service	Who helps?	How Often	Comments
Home Help			
Home Maintenance			
Meals on Wheels			
Personal Care			
Activity Group			
Respite			
Carer Support			
District Nurse			
Alzheimers Australia			
Package of Care			
Other			

Other help:

_____

_____

_____

My typical day, including when I like to shower, eat, go to bed and routines would include:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In bed I like to wear:

□ Pyjamas □ Nighty □ Underwear □ Nothing

I drive a car: □ Yes □ No

I have had a driving test: □ Yes □ No

Date of test : _____

I have the following pets

_____

_____

_____

The following person looks after my pets if I can't:

Name: _____

Phone number: _____

I also need you to know the following:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My last CT Scan was:

Date:	**Result:**
_____	_____
_____	_____
_____	_____

My last blood tests were:

Date:	**Abnormalities:**
_____	_____
_____	_____
_____	_____

My blood pressure is usually: □ **High** □ **Low**

Date:	**Reading:**
_____	_____
_____	_____
_____	_____

My weight is:

Date:	**Weight:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My last test scores (MMSE, GDS etc) were:

Test:	Date:	Score:
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____

Other tests that I have had recently include:

Test:	Date:	Score:
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____
Test:	**Date:**	**Score:**
_____	_____	_____

Important notes:

This Record of Care Booklet was originally developed in 2007 and is continually being reviewed. Any comments can be directed to Evan Stanyer, CHERC, Bendigo Health.

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Collaborative Health, Education and Research Centre
Bendigo Health

September 2014