PATIENT AND CAREPARTNER "GRAB & GO" EMERGENCY DOCUMENTATION

This patient has been diagnosed with a rare neurodegenerative disease which may cause the patient to exhibit symptoms like: change in gait, loss of balance, changes in personality and cognition, weakened eye movements, delayed response to questions (up to ten seconds), slurred speech and difficulty swallowing, extreme changes in blood pressure when altering positions, and stiffness or clumsiness in upper or lower extremities. These diseases (progressive supranuclear palsy, corticobasal degeneration, multiple system atrophy, frontotemporal dementia, chronic traumatic encephalopathy, lewy body disease) are often misdiagnosed as symptoms initially may be mistaken for those of other conditions. All diseases lead to progressive decline and although symptomatic treatments exist, there are no treatments to slow or cure these diseases.

REMEMBER TO ALWAYS INCLUDE A COPY OF PATIENT'S ADVANCED MEDICAL DIRECTIVE AND MEDICAL INSURANCE ID CARDS

PATIENT INFORMATION

Patient Name ______________________________ Date ______________

Address ____

City ______________________________ State ________ ZIP ____________

Date of Birth ________ /________ / 19________ Patient SSN ________–________–__________

Diagnosis: ❑ PSP ❑ MSA ❑ CBD ❑ CTE ❑ LBD ❑ FTD ❑ Other ____________

Year of Diagnosis ________________ Year of Symptom Onset ______________

Primary Care Physician ______________________________________

Primary Care Physician Phone __________________________________

Neurologist/Specialist Name ___________________________________

Neurologist/Specialist Contact Number ___________________________

HEALTH CARE PROXY CONTACT INFORMATION

Name ______________________________ Relationship to Patient ______________

Contact Phone Number ____________________ Alt. Phone Number ____________________

Alternate Emergency Contact

Name ______________________________ Relationship to Patient ______________

Contact Phone Number ____________________ Alt. Phone Number ____________________

Does Patient Have Advanced Healthcare Directive? YES / NO (If YES, please attach copy)

Power of Attorney Contact Information

Name ______________________________ Relationship to Patient ______________

Contact Phone Number ____________________ Alt. Phone Number ____________________

PATIENT HISTORY

Current Symptoms	Merely annoying/ absent	Mildly interferes with function	Severely interferes with function	Additional comments
Thinking/Memory				
Impulsivity				
Visual difficulty/ light sensitivity				
Coughing/choking on solids				
Coughing/choking on liquids				
Speech				
Gait/Balance				
Manual coordination				

Prone to falls YES/ NO Backwards ____ Forwards ____

Additional Psychosocial Information (i.e. emotional state, occupation, family + residential)

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Current Medication List (dosage, frequency, administration time)

1) 2)
3) 4)
5) 6)
7) 8)

Patient is engaged in an experimental drug trial YES / NO

If YES, please provide additional info ____

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Contraindicated Medications/Known Allergies

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Recent Hospitalizations and Additional Medical Information (e.g. devices, pacemaker, etc.)

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CAREPARTNER PERSONAL INFORMATION

Please complete this section with your personal information in case of your own medical emergency.

Carepartner Name ______________________________________ Date _________________________

Address ____

City ____ State _______ ZIP _______________

Date of Birth _______ /_______ / 19_______ Patient SSN ________–_______–___________

Primary Care Physician Name ____

Primary Care Physician Contact Information ____

Health Care Proxy Contact Information

Name ____ Relationship to Patient_______________

Contact Phone Number ___________________________ Alt. Phone Number ___________________

Alternate Emergency Contact

Name ____ Relationship to Patient_______________

Contact Phone Number ___________________________ Alt. Phone Number ___________________

Does Carepartner Have Advanced Healthcare Directive? YES / NO (if YES, please attach copy)

Current Medication List (dosage, frequency, administration time)

1) 2)

3) 4)

5) 6)

ADDITIONAL MEDICAL INFORMATION

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REMEMBER TO ALWAYS INCLUDE A COPY OF CAREPARTNER'S ADVANCED MEDICAL DIRECTIVE AND MEDICAL INSURANCE ID CARDS