

PATIENT AND CAREPARTNER "GRAB & GO" EMERGENCY DOCUMENTATION



UNLOCKING THE SECRETS OF BRAIN DISEASE®

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), 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 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 ___ Sideways ___ Unpredictable ___

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

Current Medication List (tablet size, tablets per dose time, times of doses)

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

Patient is engaged in an experimental drug trial YES / NO

If YES, please provide additional info _____

Vaccinations

Medication Sensitivities/Allergies

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

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____ Carepartner 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

PET INFORMATION AND POINT OF CONTACT FOR PET CARE

**REMEMBER TO ALWAYS INCLUDE A COPY OF CAREPARTNER'S ADVANCED
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Phone: +1 347-294-2873 | Email: info@curepsp.org | www.curepsp.org
1216 Broadway | 2nd Floor | New York, NY 10001 | USA
[Facebook.com/curepsp.foundation](https://www.facebook.com/curepsp.foundation) | Twitter: [@CurePSP](https://twitter.com/CurePSP)