

# Personal Healthcare Information

## for Individuals Receiving In-Home and Home Healthcare Services

In addition to completing the Family Plan, individuals receiving in-home and home healthcare services should compile the following information:

Name \_\_\_\_\_  
 Gender \_\_\_\_\_ Blood Type \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Primary Care Physician Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Pharmacy \_\_\_\_\_ Telephone Number \_\_\_\_\_

**Current Medications**

Name	Dose	Prescribing Physician

If necessary, use additional sheets for current medications.

**Allergies (medication, foods, other)**

Name			
Reaction			

**Immunizations**

Name	Disease	Immunization Date

If necessary, use additional sheets for immunizations.

**Special Needs**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Vision Impairments  | <input type="checkbox"/> Alzheimer's                 | <input type="checkbox"/> Physical Impairments  |
| <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Dementia                    | <input type="checkbox"/> Cognitive Impairments |
| <input type="checkbox"/> Mental Impairments  | <input type="checkbox"/> Speech/Language Impairments | <input type="checkbox"/> Other _____           |

**Medical Equipment**

Item			
Provider Name			
Telephone No.			
Repair Co. Name			
Telephone No.			

**Local Utilities**

Name			
Address			
Telephone No.			

**Dietary Needs**

Feeding Tube       Diabetic       Other \_\_\_\_\_

**Past Surgeries (within the past six months)**

Type		
Date		
Physician		

If necessary, use additional sheets for past surgeries.

**Who Will Help You Evacuate?****Back-up**

Name		
Address		
City		
State		
Zip		
Telephone		

**Vial of Life & Advanced Care Directives**

Vial of Life - Location \_\_\_\_\_  
 Advanced Care Directives - Location \_\_\_\_\_

**Current Plan of Care**

In-Home or Consumer Directed Services

Provider Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Services Provided \_\_\_\_\_

Home Healthcare

Provider Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Services Provided \_\_\_\_\_

Hospice

Provider Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Services Provided \_\_\_\_\_

**Also, remember to:**

- take your emergency kit including medicines and medical equipment with you if you must evacuate.
- notify providers with your evacuation or relocation information so they can continue services, if necessary.

**Discuss this information with your entire family.**

To learn more about preparing for an emergency, visit [health.mo.gov/emergencies/readyin3](http://health.mo.gov/emergencies/readyin3) or contact your local public health department.

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