ASSISTANCE AND REFERRAL CENTRE
Tools for Caregivers
www.arc-hss.ca

HEALTH INFO SUMMARY

DISCLAIMER: This tool is for general informational purposes only to assist informal/family care partners and was developed by the ARC Caregivers Team in consultation with the Caregiving Community. It is not intended to serve as a medical record. ARC assumes no responsibility for any inaccuracies/omissions.

PERSONAL INFORMATION

Name at birth

Prefers to be addressed as

Preferred Pronouns:

Mother's Maiden Name

MEDICARE NUMBER

expiry:

AGE

_____ / _____ / _____
year / month / day
DATE OF BIRTH

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary/Non-conforming ☐ Other/Prefers not to indicate

PERMANENT ADDRESS

number | street name | apt # if any | municipality | postal code

Status ☐ Single ☐ Married or Common Law ☐ Divorced ☐ Widowed ☐ Other/Prefers not to indicate

IF LIVING IN A RESIDENCE - LONG TERM CARE - CHSLD

INSTITUTION

CARE UNIT - FLOOR

CONTACT NAME

TELEPHONE

EMERGENCY CONTACT DETAILS - NEXT OF KIN

NAME: **RELATIONSHIP:**

NAME: **RELATIONSHIP:**

NAME: **RELATIONSHIP:**

POWER OF ATTORNEY *Please provide details - include documentation if possible*

☐ YES ☐ NO

RESUSCITATION STATUS (IF KNOWN) *Do not complete unless official/legal documentation included*

HOSPITAL OF CHOICE

ABOUT ME: THINGS I'D LIKE MY HEALTH CARE TEAM TO KNOW ABOUT

Your health providers appreciate knowing more about you so they can deliver the best care. For example: Do you have a prosthetic/prostheses or implant(s)? Food intolerances or special dietary practices related to cultural/personal beliefs? Details to share re: sleep habits? If you smoke/vape, consume alcohol, or use recreational drugs including cannabis products, this is useful info for your team.

- ☐ I wear glasses ☐ visual impairment
- ☐ I am hard of hearing/use hearing aid(s)
- ☐ I have mobility issues: i.e. use a walker/cane
- ☐ I wear full or partial dentures
- ☐ I use diapers/aids/need bathroom assistance
- ☐ I need assistance to get dressed/undressed
- ☐ I live alone ☐ w/other(s) _____
- ☐ I require help to read/sign documents
- ☐ I use CPAP/BiPAP/other device at home for sleep apnea /other condition
- ☐ Language(s) I speak _____
- ☐ I need interpretation/translator services if family member or caregiver is not present
- ☐ Vegetarian diet ☐ Vegan diet

CURRENT MEDICAL INFO & SURGICAL HISTORY

RECENT HOSPITAL ADMISSIONS

DATES	HOSPITAL	REASON

NAME OF PHARMACY USED

KNOWN ALLERGIES - INCLUDING MEDICATION AND FOOD

FOLLOWED BY CLSC *IF YES - PLEASE PROVIDE NAME/CONTACT INFO FOR SOCIAL WORKER*

YES ☐ NO ☐

:

FAMILY DOCTOR/PRIMARY CARE PROVIDER *IF YES - PLEASE PROVIDE NAME/CONTACT INFO*

YES ☐ NO ☐

NAME OF PROFESSIONAL:

CLINIC - OFFICE LOCATION:

KNOWN TO OTHER HEALTH CARE PROFESSIONAL(S) - *IF YES PLEASE PROVIDE NAME(S) AND SPECIALTIES IF POSSIBLE*

YES ☐ NO ☐

MEDICAL HISTORY

YEAR	CONDITION/DIAGNOSES

SURGICAL HISTORY

YEAR	PROCEDURE	HOSPITAL OR CLINIC

CURRENT MEDICATION LIST

MEDICATION INCLUDING DOSAGE	PRESCRIBED BY WHOM	START DATE

OTHER: NATURAL - OVER-THE-COUNTER PRODUCTS & VITAMIN SUPPLEMENTS CURRENTLY USED

	frequency	*since when?*
	frequency	*since when?*
	frequency	*since when?*
	frequency	*since when?*

This document was completed by

first name _____ family name _____

signature _____

relationship to care recipient _____

year _____ / month _____ / day _____