1-833-233-1445
1-888-658-5055
info@nurseonboardottawa.ca
www.nurseonboard.ca

1. MEDICAL INFORMATION..... PRINT AND PLACE ON REFRIGERATOR OR NEARBY..... IN CASE OF EMERGENCY DIAL 911 .... GIVE THIS INFORMATION TO PARAMEDICS UPON ARRIVAL

2. Patient Information

Today's Date	First Name	Last Name	Preferred Name

Sex	Birthdate	Home Phone	Cell Phone

Email Address	Address	City	Province	Postal Code

Health Card Number	Province if not ON	Ethnicity/Religion	Language spoken/written

Use of mobility aids (check all that apply)
☐ cane ☐ hoyer lift ☐ motorized scooter ☐ prosthetic limb ☐ walker ☐ wheelchair

3. DNR and Allergies/Sensitivities/Intolerances

Do you have a Do Not Resuscitate form (DNRC)	If yes, where is your DNRC form? (HAVE IT CLOSE BY)

Do you have life-threatening allergies?	List if applicable	Do you have an Epi Pen?

Do you have intolerances/sensitivities?	List if applicable	Do you wear a Medic Alert?

4. Nurse On Board Care Manager Contact Information (Main office number: 613.656.1956)

Registered Nurse Full Name	Cell Phone

Notes

5. Emergency Contact/ POA information

Full Name	Relationship	Cell Phone

POA - Personal Care	POA - Property	Notes

Name of Lawyer	Lawyer phone number	Lawyer notes

6. Medication Information: Barriers to use & adverse reactions

How do you organize your medication/supplements?

If you have barriers to taking your medication or supplements, please explain.

7. VISION HISTORY: Please select all of the following options that apply

- ☐ Blind
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Glasses
- ☐ Contact Lens
- ☐ Poor Vision

Provide more information if necessary

8. AUDITORY/EAR HISTORY: Please select all of the following options that apply

- ☐ Poor Hearing/Deaf
- ☐ Left Hearing Aid
- ☐ Ear Infections
- ☐ Tinnitus
- ☐ Right Hearing Aid
- ☐ Dizziness/Vertigo

Provide more information if necessary

9. HEAD & NECK HISTORY: Please select all of the following options that apply

- ☐ Headaches
- ☐ Migraines
- ☐ TMJ
- ☐ Jaw Issues
- ☐ Teeth Issues
- ☐ Head/Neck Surgery

Provide more information if necessary

10. RESPIRATORY HISTORY: Please select all of the following options that apply

- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pneumothorax
- ☐ Pulmonary Embolus
- ☐ Shortness of breath

Provide more information if necessary

11. DIGESTIVE HISTORY: Please select all of the following options that apply

- ☐ Crohn's
- ☐ Diverticulitis
- ☐ GERD
- ☐ IBS
- ☐ Ostomy
- ☐ Swallowing Issues
- ☐ Ulcer
- ☐ Weight Gain
- ☐ Weight Loss

Provide more information if necessary

12. SLEEP HISTORY: Please select all of the following options that apply

- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Poor Sleep Quality

Provide more information if necessary

13. CIRCULATORY HISTORY: Please select all of the following options that apply

- ☐ Anemia
- ☐ Blood Clots
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Congestive Heart Failure
- ☐ Deep Vein Thrombosis
- ☐ Heart Attack/Dysfunction
- ☐ High Blood Pressure
- ☐ Internal Defibrillator
- ☐ Irregular heartbeat
- ☐ Low Blood Pressure
- ☐ Numbness +/- tingling
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Stroke/TIA
- ☐ Loss of Sensation: Hand/Arm
- ☐ Loss of Sensation: Foot/Leg
- ☐ Varicose Veins

Provide more information if necessary

14. SKELETAL/PAIN HISTORY: Please select all of the following options that apply

- ☐ Amputation
- ☐ Congenital abnormalities
- ☐ Generalized Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Neck pain
- ☐ Pelvic Pain
- ☐ Osteoarthritis
- ☐ Tailbone Pain
- ☐ Spinal surgery

Provide more information if necessary

15. ORGAN HISTORY: Please select all of the following options that apply

- ☐ Autoimmune Disorder
- ☐ Bladder Issues
- ☐ Cancer
- ☐ Dementia
- ☐ Diabetes
- ☐ Gallbladder Issues
- ☐ Gynecological Issues
- ☐ Kidney Issues
- ☐ Liver Issues
- ☐ Pancreas Issues
- ☐ Prostate Issues
- ☐ Reproductive Issues
- ☐ Seizure Disorder
- ☐ Skin Issues
- ☐ Urinary Issues

Provide more information if necessary

16. Mental Health History

Select all that has been or is currently applicable

Additional details

17. Pet Care Information

Do you have any pets?

#1 Pet name/type/age

#2 Pet name/type/age

#3 Pet name/type/age

Name of pet sitter

Sitter phone number

Sitter details

Vet name

Vet phone number

Vet location

Pet special instructions

18. HOSPITAL BAG CHECKLIST (In advance, place what you can in a bag, so you are ready to go)

Items

- ☐ Health card (leave valuables at home)
- ☐ Cell phone ☐ Charger for phone
- ☐ Book and/or e-reader
- ☐ Charger for e-reader
- ☐ Glasses/contact lens
- ☐ Cleaner for glasses/contacts
- ☐ Headphones +/- ear plugs
- ☐ Comfortable shoes/slippers
- ☐ Warm sweater ☐ Warm socks
- ☐ Pajamas ☐ Robe ☐ Change of clothes
- ☐ Deodorant ☐ Lip balm ☐ Moisturizer
- ☐ Hair brush ☐ Sleeping mask
- ☐ Toothbrush/dentures
- ☐ Toothpaste/denture cleaner
- ☐ Facial tissue ☐ Notebook and pen